S. Hrg. 98-695

THE CRISIS IN MEDICARE: PROPOSALS FOR REFORM

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

SIOUX CITY, IOWA

DECEMBER 13, 1983

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
31-634 O WASHINGTON : 1984

S141-6

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THE CRISIS IN MEDICARE: PROPOSALS FOR REFORM

TUESDAY, DECEMBER 13, 1983

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Sioux City, Iowa.

The committee met, pursuant to notice, at 1:05 p.m., in the city council chambers, Sioux City, Iowa, Hon. Charles E. Grassley presiding.

Present: Senators Grassley and Pressler.

OPENING STATEMENT BY SENATOR CHARLES E. GRASSLEY, PRESIDING

Senator GRASSLEY. I would like to welcome you all to this hearing held under the auspices of the Senate Special Committee on Aging and say I am especially pleased that there is such a fine turnout in view of the weather. I had a little trouble myself. I had missed a plane by 10 minutes in Minneapolis this morning and had to fly to Omaha and then to Sioux City. So I feel fortunate that I am able to be here. Senator Pressler was going to be here right at 1 o'clock, and I had sent word along that he should start the hearing should I be late. Now I have word that he is not going to be able to be here until about 2 o'clock. When Senator Pressler arrives, he probably will want to make an opening statement, and then we will each participate in the questioning as long as he can be here.

I want to give a special thanks to our witnesses, who were most gracious in dealing with the postponement of the original hearing. For those of you who haven't followed this, we were originally going to have this hearing on the second Friday in November. It was postponed because the Senate had a late session Thursday night and was scheduled to be in session both Friday and Saturday. At least one of the witnesses here today was also here November 11, so he's really put 2 days into this hearing. I want to thank all of you for accepting the postponement and coming back now to be with Senator Pressler and me.

First, I need to take some time to get a few preliminaries out of the way. We have already notified witnesses that we would like to have them limit their oral presentation to 7 minutes to leave plenty of time for questioning; and just so that all of you understand standard procedure, unless you request otherwise, your written statement will be included in the printed record of the hearing as well as oral comments that you make. So it will be automatic that the statement you present and that you summarize orally will be in the printed record.

We're going to give members of the audience an opportunity to contribute to the hearing as well, by writing their comments on a special form which is available here. Those who have prepared statements, written or typewritten, may leave a copy with our staff after the hearing has adjourned, for inclusion in the record. I must say, though, that only those statements provided in writing will be made an official part of the hearing record.

The purpose of this hearing this afternoon is to hear comments on the looming crisis in medicare and to examine the various options for reforming the program. Medicare was established in 1965 as a means of providing insurance protection for the aged against the costs of health care. Coverage has since been broadened to include disabled individuals and those suffering from end-state renal disease.

It is important that we remember that medicare consists of two different parts—the physician part and the hospital services part. Part A, or the health insurance portion, pays for short-stay hospital inpatient care and is paid through payroll taxes assessed on the worker and the employer. Part B, or the supplementary medical insurance part, covers physician visits, outpatient services, and other miscellaneous medical care. Financing for part B is based on premiums paid by enrollees and on funds from the general fund of the Federal Government.

The focus of this hearing will be on part A, the hospital insurance portion. Although it would be misleading to say that the medical insurance part of medicare is in good shape, it does not face the immediate crunch which the health insurance trust fund is confronting today. This is due to the fact that by law the Government must contribute money sufficient to guarantee the solvency of the SMI trust fund. However, it would be unwise to conclude that the SMI program is in no need of reform.

Perhaps no other Federal program has so drastically affected a private industry as medicare has affected the health care industry. Medicare provides health coverage to more than 30 million Americans and is responsible for vastly improving the quality of health care available to those individuals. The Federal Government has a firm commitment to maintaining the medicare program. I was just asked this within the last half hour on a TV program, and I wanted to take that opportunity to assure people that I know of no one in the Congress who isn't committed to maintaining the medicare program. In fact, this year, as an indication of this commitment, we're going to spend $40 billion to guarantee the health care of medicare beneficiaries.

The cost of providing health services is skyrocketing. The inflation in the health care industry has risen as much as three times as fast as the annual inflation rate as measured by the Consumer Price Index. Health care cost inflation has critical implications for the solvency of the health insurance trust fund. It is essential to better understand the causes of that inflation and how to control it if we are to find solutions to the medicare financing problem.

The Congressional Budget Office estimates that the health insurance trust fund could be exhausted as early as 1988. I'm sure everybody in this room is aware of that fact, because it's been discussed so much recently. The present financing system would have to be altered substantially to bring the program into actuarial balance. To shed some light on the magnitude of the problem, the trustees of the hospital insurance program reported that either outlays will have to be reduced by 30 percent or income to the fund increased by 43 percent in order to keep the trust fund solvent over the next 25-year period. The projected cumulative deficit of the health insurance trust fund will equal $300 billion by 1995. Medicare is the fastest growing program in the Federal budget. In 1966, Federal health outlays represented 2 percent of the budget. Last year, 1982, it had grown over 10 percent.

Clearly, Congress must take action to restore solvency to this vital program. The crisis is real. The solution to the problem will not be easy or painless. We must address this serious situation in an evenhanded manner. In my view, any legislation which seeks to reform medicare must fulfill several basic requirements: It must be fair, it must protect the beneficiaries, and it cannot shift the burden solely to the private sector or to the taxpayers.

Congress did take a first step toward restructuring medicare by implementing a change in the way hospitals are reimbursed for medicare services. We need to monitor closely the impact of this change on the overall system and continue to develop other innovative methods to control the upward spiral in hospital and medical costs. I'm sure that some of the testimony today is going to speak to this dramatic change that's already been made.

The Congressional Budget Office, from which we will receive testimony later, has outlined three broad areas for reform. These options include reduction in the reimbursement of the providers of health care—the hospitals and physicians; changes in the benefits structure; and increased taxes. If anything is self-evident in evaluating these options, it is that no one sector can shoulder the entire burden of saving and preserving medicare. A carefully crafted package which balances the needs of all concerned is what Congress must strive for. That is why we must start now to fashion such a plan. All potential solutions require tradeoffs deserving careful scrutiny.

The elderly of this Nation are faced with special circumstances. By and large, they live on fixed incomes and are particularly vulnerable to high health care expenditures. Their concern with health care costs expand beyond hospitals and doctor expenses. They are also faced with tremendous costs of drugs, long-term care, and other costs that often fall outside the realm of medicare coverage.

The providers of medicare services have responsibilities to patients other than medicare beneficiaries and must look out for those private patients' concerns as well. Any recommendations for medicare should strike a careful and delicate balance between various health care users and providers.

Of course, we all know that the pressure is building now in Congress to take action. This hearing will contribute to the growing debate on how to best address the funding shortfall. I have asked the witnesses to comment in particular on their perception of the problems confronting medicare, the pros and cons of various reform proposals, and to evaluate the new prospective payment system for hospitals.

The comments we hear today will contribute to the accumulating record on how best to insure a solvent health insurance program for our Nation's elderly. I look forward to hearing the comments of our witnesses today.

The shorthand reporter is recording the proceedings for the official transcript and report of the hearing. Please be prepared to stop your testimony, as she may have to change paper and things like that. So be aware of any signal from the reporter.

I want to now introduce our first witness. This is Gene Hyde. I'd ask you to come to the witness table, Gene. He is region VII administrator of the Health Care Financing Administration. We refer to that in Washington as HCFA, as you probably do yourself. The Health Care Financing Administration is that agency of the Federal Government which administers the medicare program and the Federal part of the medicaid program.

I want to thank you very much for being here. You were the one I was referring to who came out from Kansas City on Veterans Day to testify before our hearing, and I want to, for a second time today, tell you how sorry I am that we had a forced cancellation of that hearing.

Your statement and your responses to questions will constitute a very important part of our hearing record, because HCFA is one of the key players in the executive branch on medicare issues. Please proceed with your statement, and then I'll have some questions I'll want to ask you.

STATEMENT OF GENE HYDE, KANSAS CITY, MO., ADMINISTRATOR, REGION VII, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HYDE. Thank you, Senator.

It's always a pleasure to come to Sioux City, even twice in the past month. I'm happy to be here today to discuss the crisis in the medicare program and to outline proposals for reform from the perspective of the Health Care Financing Administration.

Since its inception in 1966, medicare has been successful in assuring access to high-quality health care for its 29 million beneficiaries. However, today medicare's financial status is precarious. In spite of our collective efforts to slow the program's growth, program costs between 1979 and 1982 grew at an average rate of over 19 percent. While we have succeeded in slowing the growth of medicare, overall health care costs have continued their rapid climb. I'd like to cite a few figures.

Health care costs rose over 12 percent last year, almost three times the national inflation rate. Health care costs consumed 10.5 percent of the gross national product in 1982 compared to 6 percent in 1965. The cost of an average hospital stay has increased from $316 in 1965 to $2,168 in 1981. The cost of physician services is increasing at an average annual rate of over 12 percent at a time when the general inflation rate is 4 percent. In 1982, medicare paid out $49 billion in benefits, more than five times the outlays in 1973.

These figures raise a real concern that we are on the verge of an era in which the quality of health care for which our country is famous may no longer be affordable for the average American, and ultimately the medicare program may no longer be able to fulfill its commitment to the Nation's elderly. Without changes, medicare's hospital insurance trust fund could be exhausted by 1990.

As you are aware, implementation of the prospective payment provisions for inpatient hospital services under medicare began on October 1. This is but the first step toward improving the financial foundation of medicare. The passage of prospective payment, when coupled with the enactment of the National Commission on Social Security's recommendations, dramatically improves the short-term financial condition of the hospital trust fund. It does not, however, resolve the basic solvency issue. The trust fund will still be exhausted by the end of this decade unless further improvements are made.

Looking at the long-term, 25-year projection from 1983 through 2007, the average cost of the medicare program, expressed as a percent of payroll, will be 4.31 percent. During the same 25-year period, the average current tax law rate is but 2.87 percent. In other words, either program costs will have to be reduced 30 percent or hospital insurance payroll taxes will have to be increased by 43 percent to keep the program solvent over the next 25 years.

The Senate Finance Committee on which you serve and other committees of the Congress are considering proposals to control medicare costs. The administration has proposed incentive, reimbursement, and financing reforms designed to control inflation and encourage competition in the health care marketplace. I'd like to discuss some of these proposals.

Let me first describe one of the incentive reforms. Last year, Congress, with the support of the administration, amended the medicare statute to permit payments on a risk basis to health maintenance organizations and other competitive medical plans. We are proposing to expand this to include an optional voucher provision which would allow medicare beneficiaries to use medicare benefits to purchase a wide array of private health plans. Medicare would issue a voucher to the beneficiary in an amount equal to 95 percent of what it would cost to provide health care in the traditional manner. The beneficiary would use this voucher to purchase a private health plan. If the beneficiary selected a plan that costs more, the beneficiary would pay the additional amount. If the beneficiary selected a cheaper plan, the beneficiary would qualify for a cash rebate.

We believe this proposal would promote competition among health insurers, leading to improved prices and benefit packages. It would also give beneficiaries an incentive to shop for the best deal.

One of the reimbursement reforms we are proposing would provide for a temporary freeze on physician payments. Physician payments constitute the second largest component of medicare expenditures, 23 percent of the total. Payments to physicians increased by 21 percent in 1982 to $13 billion, and will increase another 19 percent in 1983. We propose to freeze the physician payment level for 1 year.

I'd like to briefly discuss the administration's proposal to restructure beneficiary cost sharing under the hospital part of medicare. This proposal is intended to affect physician behavior in admitting and keeping patients in the hospital.

Under the current system, medicare inpatient hospital coverage is limited to 90 days in a benefit period and 60 lifetime reserve days. After the first-day deductible, there is no beneficiary cost sharing until the 61st day of hospital care in a benefit period. This places the greatest financial burden on the sickest patients. Less severely ill patients and their physicians have little incentive to keep their hospital stays as short as possible.

Our proposal would change the beneficiary cost sharing to create incentives for savings where appropriate and to better protect the medicare patient who suffers a long catastrophic illness. Under restructured cost sharing, the beneficiary would still pay the initial deductible, which will be $356 in 1984, and would then pay about $28 a day for the 2d through the 15th day of the hospital stay, and about $17.50 a day for the 16th through the 60th day of the stay. After the beneficiary has shared in the cost for 60 days in a calendar year, there would be unlimited hospital days without additional beneficiary cost sharing.

I want to mention one other proposal designed to stimulate consumer awareness. Although it does not deal specifically with the medicare program, it impacts directly on the total health care costs which affect us all. At present, all employer contributions to employee health benefits are tax free to the employee. We propose to limit this tax subsidy, which encourages individuals to overinsure. Our proposal would allow tax-free treatment only up to $175 per month for family coverage and $70 per month for individual coverage.

In conclusion, I believe the proposals which I have just described would not only improve the financial condition of the medicare program, but also would have a positive impact on the Nation's total health care costs. We look forward to working with you to assure that quality health care will continue to be available to all Americans. I welcome your questions on our proposal.

Thank you.

Senator GRASSLEY. Thank you, Mr. Hyde. Your prepared statement will be inserted into the record at this point.

[The prepared statement of Mr. Hyde follows:]

PREPARED STATEMENT OF GENE HYDE

I am happy to appear today to discuss "The Crisis in Medicare: Proposals for Reform" from the perspective of the Health Care Financing Administation (HCFA).

Since its inception in 1966, medicare has been successful in achieving its main objective: providing high quality health care to its beneficiaries. Today, over 26 million aged and another 3 million disabled persons are covered under medicare. Prior to medicare, many of these people did not have access to adequate health care. Medicare has assured the aged and disabled that they need not fear the burden of high hospital or physician bills.

However, medicare's financial status is precarious. As I will discuss shortly, we and the Congress have made major efforts over the past 3 years to slow the program's growth, but in spite of these efforts, program costs between 1979 and 1982 grew at an average rate of over 19 percent. While we have succeeded in slowing the growth of medicare over the past 2 years, overall health care costs have continued their fast climb. I would like to cite a few figures:

Health care costs rose over 12 percent last year, almost three times the national inflation rate.

Health insurance costs rose almost 16 percent in 1982.

Health care is consuming an ever-larger portion of the Nation's output—10.5 percent of the GNP in 1982, compared to 6 percent in 1965.

The cost of an average hospital stay has increased from $316 in 1965 to $2,168 in 1981.

The cost of physician services is increasing at an average annual rate of over 12 percent at a time when the general rate of inflation is 4 percent.

In fiscal year 1973, medicare outlays were $9 billion. Scarcely 10 years later, in fiscal year 1982, medicare paid over five times that—or $49 billion—for benefits.

Taxpayers feel the burden of these costs now, and will continue to do so, as the cost of medicare and medicaid continues to rise in the future.

These figures raise a real concern that we are on the verge of an era in which the quality of health care for which our country is famous may no longer be affordable for the average American. And, ultimately, the medicare program may no longer be able to fulfill its commitment to the nation's elderly. Without changes, medicare's hospital trust fund could be exhausted by 1990. The supplementary medical insurance trust fund, originally intended to be supported by equal contributions from general revenues and premiums, currently derives only about 25 percent of its income from payment of premiums while the remainder comes from general revenues.

As you are aware, the prospective payment provisions for inpatient hospital services under medicare were enacted as a part of Public Law 98-21, the Social Security Amendments of 1983. The prospective payment approach is but the first step toward improving the financial foundation of medicare. I believe it is important to point out that a part of the reason for the huge increase in hospital costs has been a retrospective cost reimbursement system that rewards inefficiency.

In adopting most of the administration's prospective payment proposal, Congress removed the disincentives of the cost-based system and substituted instead a system under which hospitals will know in advance the amount they will be paid for each case. Hospitals that perform efficiently will be able to keep the difference between their costs and the prospective rate, while those hospitals whose costs for the same care are high will have to make up the difference. The prospective payment system went into effect October 1, and most hospitals will be covered under this system by next September. The passage of prospective payment, when coupled with the enactment of the National Commission on Social Security's recommendations, dramatically improves the short-term financial situation of the hospital insurance trust fund. Nevertheless, it does not solve the basic solvency issue as, even with the passage of these provisions, the fund still will be exhausted by the end of this decade.

The projections in the hospital insurance trustees report, including prospective payment and the provisions of the bipartisan agreement on social security reform which affect the hospital insurance program, indicate that the hospital insurance trust fund will be depleted in 1990 under alternative II-B assumptions or as early as 1988 under the more pessimistic alternative III assumptions.

Looking at the long-term, 25-year projection from 1983 through 2007, the average cost of the program, expressed as a percent of payroll, will be 4.31 percent. During that same 25-year period, the average current law tax rate is 2.87 percent. In other words, either program costs will have to be reduced 30 percent or hospital insurance payroll taxes will have to be increased by 43 percent to keep the program solvent over the next 25 years.

As you know, the Quardrennial Advisory Council on Social Security has been analyzing the financial problems of the hospital insurance trust fund and exploring long-range options for resolution of these problems. This prestigious group began its work last November and will report its findings and recommendations at the end of this year.

As we await the recommendations from the Advisory Council on Social Security, we are continuing to conduct a wide variety of demonstrations and experiments. These are designed to test new and innovative methods of providing care in a cost-effective manner. These should further help to assure the future success of medicare.

Recently, the Senate Finance Committee, on which you serve, and other committees of the Congress have been considering proposals to reduce medicare costs. The incentive and reimbursement reforms proposed by the administration for 1984 are designed to control inflation and encourage competition in the health care marketplace by:

Creating positive economic incentives for providers and patients to control costs, and calling on physicians, hospitals, insurers, consumers, employers, and government to work together and share the responsibilities for controlling costs.

I would like to describe some of the incentive, reimbursement, and financing reforms we, in the administration, have proposed.

INCENTIVE REFORM

Voluntary voucher

Last year, Congress, with the support of the administration, amended the medicare statute to premit payments on a risk basis to health maintenance organizations and other competitive medical plans. This year we are proposing to expand this provision. The optional voucher provision would build on current law by allowing medicare beneficiaries to use medicare benefits to enroll in a wider array of private health plans. Medicare would contribute an amount equal to 95 percent of what it would have cost to care for the beneficiary if he or she had elected traditional medicare coverage. If a beneficiary selects a private health plan that costs more than medicare's contribution, the beneficiary would pay the difference. If the private plan costs less than medicare's contribution, the beneficiary would qualify for a cash rebate.

We believe this proposal would promote competition among health insurers to improve their prices and benefit packages, and it would give beneficiaries an incentive to shop for the best deal. These incentives would encourage cost-conscious behavior on the part of both beneficiaries and providers and so would contribute to our efforts to constrain health care costs.

REIMBURSEMENT AND FINANCING REFORMS

We also are proposing important medicare reimbursement and financing reforms. This series of proposals complements our proposed incentive reforms by assuring that all parties share equally in controlling medicare costs and by improving certain mechanisms which help to finance the medicare program.

Temporary freeze on physician reimbursement

Medicare physician expenditures, the second largest component of medicare spending, have been increasing by highly inflationary rates. In 1982, they increased 21 percent to more than $13 billion, and they are expected to rise another 19 percent in 1983. Because of these large increases and because physicians were largely unaffected by the cost-control provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248, and the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, we propose to freeze the physician reimbursement level for 1 year. Since physician services are the second largest component (23 percent) of medicare spending, we believe physicians should share the burden of reducing costs in these times of fiscal crisis.

Restructured beneficiary cost sharing and catastrophic coverage under part A

I would also like to discuss briefly the administration's proposal to restructure cost sharing under part A. This proposal is intended to affect physician behavior in admitting and keeping patients in the hospital.

Under the current system, medicare hospital coverage is limited to 90 days per spell of illness and 60 lifetime reserve days. This places the greatest financial burdens on the sickest patients. Less severely ill patients, and their physicians, are given little incentive to keep their hospital stays as short as possible because cost sharing, other than paying the deductible, does not begin until the 61st day of hospitalization. At that point, the beneficiary pays $76 per day through the 90th day. Each lifetime reserve day costs $152.

Our proposal would change the cost sharing to create incentives for savings where those incentives can work and to better protect the medicare patient who suffers long catastrophic illness. Under restructured cost sharing, the beneficiary would still pay the deductible and would then pay 8 percent of the amount—about $28 per day in 1984—for days 2 through 15 of hospital care. For days 16 through 60, this amount would be reduced to 5 percent of the deductible—or about $17.50 per day. After the beneficiary has paid for 60 days of cost sharing in a calendar year, there would be unlimited hospital days without additional cost sharing.

TAX CAP

I want to mention one other proposal designed to stimulate consumer awareness of the cost of health care. Although it does not deal directly with the medicare and medicaid programs, it certainly impacts directly on total health care costs which affect us all. At present, all employer contributions to employee health benefits are tax free to the employee. We proposed to limit this existing tax subsidy which encourages individuals to overinsure. Our proposal would allow tax-free treatment only up to $175 per month for family coverage, or $70 per month for individual coverage.

The tax cap would affect only about 30 percent of those with employment-based health coverage. These individuals would remain free to purchase as much health care coverage as they desire but with "after tax" dollars. However, the cap would remove the tax laws as an inflationry inducement for the creation of excessive benefit plans or unreasonably high-priced insurance premiums.

In conclusion, I believe our major 1984 proposals, which I have just described, would not only improve the financial condition of the medicare program but also would have a positive impact on the Nation's total health care costs.

Our proposals would do this by providing positive incentives for cost effectiveness. By working together, we have established an admirable record in beginning to contain health care costs that previously seemed uncontrollable. We look forward to building on this foundation so that we may continue to assure that quality health care is available to all Americans.

I welcome your questions on our proposals.

Senator **Grassley**. First of all, as you may know, in addition to my serving on the Special Committee on Aging, I also am a member of the Senate Finance Committee. I appreciate your people in Washington who have been so very helpful to me as a member of the Finance Committee which actually has jurisdiction over the changes that are to be made in medicare. And we study issues a long time. It's very difficult to get a consensus on what to do; and, of course, I would hope that a hearing like this will help us develop such a consensus.

The administration's budget request for the medicare function for the current fiscal year 1984, was to save $11 billion over 3 years.

Considering that $11 billion in recommended savings versus the magnitude of the financing problems facing the health insurance trust fund, are greater and more sweeping changes needed and needed soon? And from that standpoint, it could appear that the administration's package is really a drop in the bucket. Assuming you agree with that premise, should we be expecting for the next year the administration to suggest even more sweeping changes than they have?

Mr. **Hyde**. We certainly, without question, agree with your assertion of the magnitude of the problem. It is a major problem. We believe, too, that reforms must be broadly based. You indicated in your statement that there are three major players in this issue—the beneficiaries, the providers, and the taxpayers—and I think that to deal with this issue there does have to be a balanced approach which will require that all parties make a contribution in order to keep the program on a sound financial basis.

The proposals that will be coming forward will be broad. They will not only apply directly to the medicare program, but will also attempt to influence the health care delivery system in general in the marketplace. There are a number of parties that are developing proposals. We expect that the medicare conference of 2 weeks ago sponsored by the House Ways and Means Committee, the Congressional Budget Office, and the Congressional Research Service will provide some ideas as to how to deal with the problem.

As you know, the Quadrennial Advisory Council will be coming forward with its report and recommendations later this month to the Secretary and to the Congress. The problem is of such a magnitude that it will take everybody's contribution to develop the solutions, and I think that ultimately the solutions will be developed, and the medicare program will continue to serve the people as it was initially designed.

Senator **GRASSLEY**. Probably, then, we'll wait for the Quadrennial Advisory Council's reports until we get any indication as to what the committee is going to specifically do.

Mr. **HYDE**. Yes, I think so.

Senator **GRASSLEY**. And that's what you hear within your department?

Mr. **HYDE**. A number of proposals were put forth a year ago by the administration, including the voucher proposal and the tax cap proposal; and I think, with the additional study that has been going on, some of those proposals will be rethought, and I would imagine be put forward again by the administration in January.

Senator **GRASSLEY**. It's apparent to everyone, I'm sure, that anything we do in the way of reform has got to zero in on the inflation that is occurring in the health care field, and we have to do it in a way that avoids simply cost-shifting measures—where we save someplace and somebody else is going to pay for it. We have to avoid that sort of thing.

What evidence do you have that cost-sharing proposals would alter beneficiary behavior and act as a brake on ever-escalating costs? Given the fact that the vast majority of health care decisions are made by physicians, is it fair to assume beneficiaries could alter their utilization patterns on their own, since most of it comes at the instigation of the health care professional?

Mr. **HYDE**. As you may know, the Rand health insurance demonstration, which is sponsored by the Department, has given some preliminary indication that cost sharing does influence the behavior of individuals. In this study, adults in plans with cost-sharing provisions had a hospital admission rate which was one-third lower than those in plans that had no cost sharing. The study also indicated that individuals in plans with cost sharing had one-third fewer physician visits than those in plans that had no cost sharing. Earlier, there was a California experiment that related to the medicaid program, and it also indicated that cost sharing does reduce utilization.

These studies also indicate—and I think this is very important—that cost sharing did not prevent patients from acquiring the care that they needed for serious health problems.

Senator **GRASSLEY**. It is generally assumed that the prospective payment system is going to make hospitals more efficient. How do we know that the quality of service is not going to suffer, and are there any plans that have been made by this administration for monitoring the workings of the prospective reimbursement system to see that quality doesn't diminish?

Mr. **HYDE**. Yes.

As you know, the prospective payment system started on October 1, and each individual hospital comes under that program with the hospital accounting year that begins October 1, 1983, or later. So, we're in the early stages of the implementation of prospective payment. A number of different programs have been put in place to monitor the operation of the prospective payment system. A number of these devices are in place to assure that patients do not suffer from this new system. We have a quality-assurance program which is to look at hospital admissions, readmissions, transfers, and early discharges; and we also have, as you may know, proposed adding a quality assurance standard to the conditions of participation for a hospital to participate in the program. We are also stressing good discharge planning.

Activity in States that have had ratesetting programs or some other form of fixed hospital reimbursement has indicated that the quality of care does not suffer under these programs. We will be developing, in addition to those that we already have in place, additional kinds of systems as we gain experience to insure that the quality has not declined.

Senator **GRASSLEY**. You went into some detail about the restructured cost-sharing plan that the administration is putting forth, and you described a beneficiary in a hospital for 60 days would pay approximately $1,451. Cannot beneficiaries reasonably say this constitutes too heavy a burden to ask them to shoulder, particularly because catastrophic provisions would help only a small percentage of medicare beneficiaries while the extra cost of up-front care in the early days of a hospitalization would affect a much larger group of people?

Mr. **HYDE**. Under the current system a beneficiary who stayed in the hospital for 150 consecutive days would have a cost sharing of more than $13,000. I think that we ought to look back to one of the initial premises on which the medicare program was based, and that is to assist individuals in meeting their medical needs and to assure that they maintain some financial viability and that they are not forced into bankruptcy because of health care needs. I think there has to be some kind of way to balance the contribution that individual beneficiaries must make and, at the same time, provide for the catastrophic protection that is anticipated by this proposal.

Senator **GRASSLEY**. It's a very difficult thing to sell. That's all I can say. I've had an opportunity to discuss it with many of my constituents, and there's a great deal of misunderstanding. It doesn't mean that it can not be understood with a little more effort; but at this point we have a tremendous selling job to do. And I don't say that with any implication that I support it, because at this point I'd have to say I do not; but I'm willing to look at all alternatives as we try to put together a package.

Moving to another question now—whether it's health care, or defense, or anything else—everybody says if we'd just eliminate fraud, mismanagement, and abuse, we'd be able to pay for the program itself. Frankly, I think that's more true of defense than it is with health care, but I think we even have problems with health care. From the standpoint of fraud, mismanagement, and abuse in medicare's program, how good is HCFA's data, particularly in avoiding duplicate payments due to a lack of an interface between parts A and B of that program?

Mr. HYDE. We're continuing to work on this, and, as you may know, there is a work group in the Health Care Financing Administration in the department that is conducting a study.

Senator GRASSLEY. That is an admission, then, that it's still a great problem?

Mr. HYDE. No.

Senator GRASSLEY. It is not?

Mr. HYDE. That is an indication that we are continuing to go try to find ways to deal with it. Prospective payment, as you know, pertains only to reimbursement for inpatient care. Outpatient care is under part B of the program. We have directed our contractors to do quarterly runs to assure that we're not paying for medical services for inpatient hospital patients as outpatients under part B. We're trying to assure that there's no double billing, that we're not getting billed under part B for services that are included in the DRG rate.

In many cases, we have the same contractor—for example, in Iowa, the Des Moines Blue Cross plan serves the part A program in part of the State and the entire State under part B—handling claims under both parts A and B, and they do have systems in place that cross-check and make sure that we're not, in fact, making duplicate payments. I would not attempt to tell you that there is no duplicate payment problem remaining. I'm sure that we do have some of those. We are continuing to work on it, and I think that we will continue to make progress in eliminating that.

Senator GRASSLEY. The administration for the last 2 or 3 years has put great emphasis upon getting more competition into health care, particularly as it would relate to medicare. An obvious component of procompetition reforms is the availability of two or more providers of health care. What implications do competition models have for rural areas of the United States? Iowa, as you know, has a tremendous number of rural hospitals. How would the adoption of a preferred-provider organization be implemented in rural areas?

Mr. HYDE. I think in any competitive situation the more competitors you have, the more success and the more benefits you are going to get from the competition approach; and I think it's fair to recognize that at the current time we won't have that competitive activity to the extent that we would like in some areas of the country. Even though while beneficiaries in rural areas may initially be limited as to the source from which they can obtain their medical care, the voucher program will give them some choice in selecting from competing plans a range of covered services, premium rates, types of practice, and so forth, that they prefer.

We would expect that insurers will not ignore the large rural markets that are out there and that they will develop plans providing for competition. True competition affects not only providers, whose numbers may be limited in rural areas, but it also affects all parties, including the consumers, by restoring incentives for cost-conscious behavior. It may take the industry more time to develop plans to meet the demands of the competitive marketplace in rural areas, but we're convinced that in time these demands will be met.

As far as preferred-provider organizations, these are relatively untested at the moment. However, we believe that such organizations will emerge in time in rural areas, giving consumers another option. As you may know, we've just initiated two demonstration projects with respect to the PPO concept, one in Denver and one in Santa Barbara, Calif., and the results of those are not available at this time.

Senator **GRASSLEY**. Did you say they are available or not available?

Mr. **HYDE**. Are not.

Senator **GRASSLEY**. Are not available.

Mr. **HYDE**. It's a process that just recently was initiated.

Senator **GRASSLEY**. I would like to turn to the issue of restructuring physician reimbursement. One of the things that we have to be careful of is to avoid those things which could harm the beneficiary population. In a very general way, what would be the effect of mandating assignment on physicians treating medicare patients?

Mr. **HYDE**. Well, I think that——

Senator **GRASSLEY**. Also, do we have any information which break out assignment statistics by specialties?

Mr. **HYDE**. Yes, we do. I have that available, and can provide it, or I'll provide it later for the record, if you would like.

Senator **GRASSLEY**. You can provide it later, but go ahead and answer my first question.

Mr. **HYDE**. With respect to the possible effect of mandatory assignments, we have no clear fix at this time. We've had no demonstrations and no clear picture as to what the overall impact will be. There has been a study of this all-or-nothing assignment requirement by the Center for Health Economic Research. That study indicated that over two-thirds of the physicians surveyed said they would take none of their bills on assignments. Assignment rates could fall from their current 53 percent level to 43 percent.

That's about all the information I currently have with respect to the possible impact of mandatory assignments; but I would mention that we have recently instructed our contractors to prepare listings of physicians with respect to the assignment issue. The listings will show by individual physician the range of frequency with which they do accept assignments; and we have made these listings available in local social security offices and at the medicare carriers, and I think that this will be of some value to the beneficiary who is looking for a physician who will accept an assignment.

[The material referred to follows:]

Assignment rates by specialty, 1977

Percent of charges assigned for aged persons:	
General practice	41.9
Family practice	44.3
Internal medicine	39.3
Cardiovasclar medicine	47.8
Dermatology	38.3
General surgery	46.5
Otolaryngology	29.3
Ophthalmology	28.7
Orthopedic surgery	42.4
Urology	39.1
Anesthesiology	46.9

Pathology	61.2
Radiology	59.0
Chiropractic	22.8
Podiatry	59.2

Source: McMillan et al., "Medicare Use of Physicians' Services Under The Supplementary Medical Insurance Program, 1975-1978," March 1983, HCFA Pub. No. 03151, table 25.

Senator GRASSLEY. Thank you. Mr. Hyde, I'm done asking questions now.

I appreciate very much your participating. I would invite you to stay if you can. If you can't, I surely will understand.

Mr. HYDE. I will stay.

Senator GRASSLEY. You may anticipate, since Senator Pressler is not yet here, that he, or any member of the Special Committee on Aging may submit questions in writing. I have one or two more that I'll probably submit in writing. Let me add for the benefit of all the witnesses, that it is standard procedure that we sometimes can't ask all the questions we would like, and if that be the case, you may have questions submitted to you in writing.

We would appreciate a response within 15 days, and I would say that is about the period of time for the correction or addition of any comments that may be made by any of the participants as well.

I thank you very much.

Mr. HYDE. Thank you, sir.

Senator GRASSLEY. Our next witness is Dr. Charles Seagrave. He is head of the Human Resources Cost Estimates Unit in the Budget Analysis Division of the Congressional Budget Office. CBO has done a great deal of work in the area of medicare and is perhaps the most authoritative voice on the financing problems facing the trust fund.

This is an extremely busy time at the Congressional Budget Office, as I am sure Dr. Seagrave will verify. I want to let you know, Dr. Seagrave, as well as others in your organization, that I very much appreciate your taking time from your busy schedule to come here. I am aware CBO is getting ready for the budget season, which is the first 3 months of each calendar year.

I might also say, for the benefit of the audience, that Dr. Seagrave was one of those who, for a short period of time was stranded in Minneapolis with me, so I appreciate very much your willingness to come. I would urge you to proceed in the same manner which I outlined to the previous witness.

Would you proceed.

STATEMENT OF DR. CHARLES SEAGRAVE, WASHINGTON, D.C., CHIEF, HUMAN RESOURCES COST ESTIMATES UNIT, BUDGET ANALYSIS DIVISION, CONGRESSIONAL BUDGET OFFICE

Dr. SEAGRAVE. Senator Grassley, first I would like to thank you and your staff for your assistance in getting here today. Without your guiding me through the Minneapolis/St. Paul Airport, through the city of Omaha, and onto a private plane into Sioux City, Iowa, I would not be here today. I appreciate your help.

Senator GRASSLEY. You probably appreciate us helping you out, too, don't you? [Laughter.]

Dr. SEAGRAVE. Medicare provides coverage of acute health care expenditures for 29 million elderly and disabled individuals. It consists of two separate programs. Hospital insurance—HI—pays for inpatient hospital care, stays in skilled nursing facilities, and home health services, whereas supplementary medical insurance—SMI—pays for all other services covered by medicare, principally physician and hospital outpatient services. The programs are financed through separate trust funds, with distinct sources of revenues. In fiscal year 1983, medicare outlays totaled almost $57 billion, of which nearly $39 billion was for HI.

Total medicare expenditures have been growing at an average annual rate of 17.7 percent since 1970, and the program faces serious financing problems for the foreseeable future. Under current policies, the HI trust fund could be depleted as early as the end of the decade, and revenue contributions required to support physician benefits will continue to rise as a proportion of general revenues.

My testimony today will discuss the factors that contribute to the growth in medicare outlays and the scope of the problem facing both portions of medicare in the next few years, and the tradeoffs among general options for dealing with the problem.

The nature and scope of the problem. Health care spending in the United States has been growing rapidly, both in absolute terms and as a percentage of gross national product. National health spending rose from 7.5 percent of GNP in 1970 to 10 percent in 1983. Projections show national health spending reaching 12 percent of GNP by the end of the decade.

The financing problems of both parts of medicare stem from the fact that payments to medical providers are expected to grow much faster than the Federal revenues available to support them. The projected growth in outlays is attributable primarily to rising medical care costs and, to a lesser extent, to the aging of the population.

The hospital insurance problem. In HI, the yearend balances will decline each year as annual outlays exceed annual income. Deficits will be small at first but will then increase rapidly. The cumulative deficit could total over $200 billion by 1995. These projections all assume that present policies remain unchanged and hence can be used as a baseline from which to judge potential changes in the medicare program.

The source of the HI problem is the gap between outlays and revenues. Over the 1982 to 1995 period, HI outlays are projected to increase at a 12.4-percent annual rate while revenues are expected to rise at only 8.7 percent per year. Changes enacted since 1982 in the way hospitals are reimbursed, and scheduled increases in the payroll tax earmarked for the HI trust fund, which are reflected in these figures, have slowed the onset of the problem but have not eliminated it.

Supplemental medical insurance problem. The rapid growth expected in SMI raises a somewhat different problem. Since, by law, appropriations from general revenues to SMI must be sufficient to guarantee the solvency of the trust fund, SMI does not face a financing crisis per se. Rather, concern arises over this part of medicare because the projected rate of growth of SMI is so much higher than the rate of growth in general revenues, that is, Federal tax revenues not earmarked for specific purposes.

As with HI, outlays under SMI are projected to increase rapidly by almost 16 percent per year through 1988. To finance this increase, general revenue contributions would have to rise even faster, at about 17 percent per year. Thus, the share of Federal tax revenues not earmarked for other purposes going to the SMI trust fund would rise from 3.7 to 5.7 percent between 1982 and 1988. If the proportion of general revenues going to SMI were held constant at 1982 levels, outlays would have to be reduced by almost $27 billion over the 1984 to 1988 period.

OPTIONS FOR SOLVING THE PROBLEM

Given the magnitude of the problems facing medicare in the next decade, incremental approaches are unlikely to provide solutions. Moreover, any single change in medicare large enough to solve the problem might have to be so substantial as to be politically unacceptable. Consequently, some combination of available options will likely be required, affecting three basic groups—providers, beneficiaries, and taxpayers.

REDUCTIONS IN REIMBURSEMENTS TO PROVIDERS

One major strategy for reducing the growth of medicare outlays would limit the amounts that medicare pays providers—that is, hospitals and physicians. To the extent that costs of providing services would be shifted to other payers, however, this approach would pass the effects of the cuts on to other users of health care.

HOSPITAL REIMBURSEMENT

In the last 2 years, the Congress has enacted major revisions in medicare hospital reimbursement. This new prospective reimbursement system establishes strong incentives for hospitals to contain costs, since hospitals that provide less expensive care can keep the difference between their reimbursements and actual costs, while less efficient hospitals do not recoup all their expenses. But the legislation left unresolved a major question: How tight the prospective rates are to be after 1985? This is to be decided by the Secretary of Health and Human Services, advised by an independent commission. While successive tightening of reimbursements would cut Federal outlays substantially, it would run a substantial risk of reducing beneficiaries' access to quality care.

PHYSICIAN REIMBURSEMENT

Currently, the level of reimbursement received by physicians under SMI is based on reasonable charges which may not exceed the lowest of physicians' actual charges, their customary charges for that service, or the applicable prevailing charges in the locality. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to cut growth of physicians' reimbursements. By 1981, average reimbursement charges were 32 percent lower than actual submitted charges.

One way to cut Federal costs further would be to apply more stringent limits to the growth of reasonable charges. For example, physicians' reimbursement rates could be frozen for a time. Alternatively, more basic changes could be made in the structure of reimbursements for particular services or types of physicians, emphasizing options that might focus on the volume of services as well as their unit costs.

As long as physicians are not required to accept assignment, however—that is, as long as they are permitted to charge patients in excess of "reasonable" charges—a portion of budget savings from reduced reimbursements would probably be achieved at the expense of higher costs for some beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment, although this could result in some physicians refusing to participate in medicare, thereby limiting beneficiaries' access to care.

CHANGES IN THE BENEFITS STRUCTURE

Beneficiaries are now required under both portions of medicare to share some of the costs of covered services. Hospitalized beneficiaries must pay a deductible amount in each benefit period but are not liable for additional cost sharing until they have been confined more than 60 days. Under SMI, the most important cost sharing is the 20 percent of each covered service that must be paid by the beneficiary once a $75 deductible has been met.

Beneficiaries could pay a greater share of the costs of medicare-covered services through higher premiums, deductible amounts, or coinsurance. Such changes could generate large amounts of Federal savings, although they would do so by substantially increasing out-of-pocket costs for the elderly and disabled. While beneficiaries have not been subject to major increases in cost sharing to date, they already pay about one-fourth of the rapidly rising costs of medicare covered services, and even more for other health services not covered by medicare.

In general, choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. For example, increases in costs to beneficiaries across the board, such as higher premiums, would affect large numbers of beneficiaries but each by only a small amount. On the other hand, options that are tied to the use of medical care services, such as a required payment for each day of hospitalization, might result in somewhat lower use of health care services, but would concentrate the additional liability on the small portion of beneficiaries who already have the highest medical expenses.

HIGHER TAXES

A third approach to maintaining the solvency of the HI trust fund would be increased tax support for the fund through higher payroll taxes or transfers from general revenues. Reliance on higher taxes would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care. But any tax increase implies that current taxpayers would be supporting a level of benefits for medicare participants that is already well in excess of contributions made by the participants. Moreover, payroll tax contributions by employees and employers are already scheduled to increase by 1.9 percentage points between 1975 and 1990—a 31-percent increase—and general revenue contributions for SMI are increasing at 16 percent a year. Further payroll tax increases could cover the HI trust fund deficit, but might have adverse effects on employment, since the costs to the employers of hiring workers might rise. Reliance on other revenues would not necessarily change the overall tax burden, but could cause higher deficits or reduce funds available for spending on other programs.

In conclusion, the projected growth in medicare outlays poses problems for controlling the Federal deficit and for insuring the solvency of the HI trust fund, problems which, without changes in current law, will continue for the foreseeable future. The size of reductions in outlays or increases in taxes that would be required to bring HI into balance over time suggests the importance of considering a combination of approaches to spread the burden among providers, beneficiaries, and taxpayers. In addition to these medicare-oriented approaches, a long-term solution to the problem of rising medical care costs would probably require changes affecting the entire system.

Senator GRASSLEY. I want to thank you very much; and again I want to emphasize the tremendous burden that Congress puts upon your agency, the CBO, for analysis of various alternatives to medicare and alternatives for improving medicare.

CBO has done a great deal of work in the area of benefit restructuring, particularly the various cost-sharing options. Now, let's speculate that we move toward increased cost sharing. How do we protect medicare beneficiaries at the margin—those who are not eligible for medicaid but who can at the same time ill afford more out-of-pocket costs?

Dr. SEAGRAVE. Well, I think there are several probabilities. One, it is possible to tie the level of cost sharing to the level of participants in them, and that way you would protect the low-income participant against the full impacts of additional cost sharing.

Second, the current medicaid program in 29 States is a program for the medically needy, those whose incomes are above those required for eligibility in the SSI or AFDC programs but who have incurred large medical expenses. If the medically needy's program and the medicaid program were expanded to all States, it would provide additional health protection to some of these groups.

Senator GRASSLEY. One thing that Congress has to carefully guard against—and I said this to the previous witness as well—is anything that does little more than simply just shift costs. It's not uncommon to hear that medicare patients have exhausted their assets and available resources and then become medicaid eligibles. How can we restructure present participation in the health insurance field to prevent that type of occurrence?

Dr. SEAGRAVE. One protection that medicare does not provide beneficiaries today is what we refer to as maximum liability insurance. This is a characteristic of many health insurance plans at this point. It is being widely picked up in private plans. It basically says that after your out-of-pocket costs have exceeded a particular limit, you will not be forced to pay any additional costs.

Certainly, providing maximum liability protection under medicare would alleviate some of these problems. On the other hand, providing maximum liability coverage in medicare in and of itself clearly has a cost associated with it, and would only be cost neutral or, in fact, would generate savings if additional cost sharing were added to the program.

Senator GRASSLEY. OK.

Again, I'd like to refer to the hospital prospective payment system that we've passed. There's been some attention given both in the private and the public sector, to expanding this system to all payers and providers. Has CBO done any work in examining the potential for such an expansion, and its effect on the quality and availability of medical care?

Dr. SEAGRAVE. We have not done a great deal on that at this point. I would make the point that Mr. Hyde made earlier today, and that is that the prospective reimbursement system in hospital insurance is just beginning to be implemented, and so we would—we, and the administration, and a number of others will be carefully watching the implementation of that system to see the results of it, and to what extent, for example, costs may be passed on to other payers in the system. But I have no work to report on that topic at this time.

Senator GRASSLEY. Then you probably won't have any information for quite a few months, even a year or so?

Dr. SEAGRAVE. I think that's fair, yes.

Senator GRASSLEY. OK.

We've been hearing a good deal of discussion lately as to the merits of means testing medicare. Again, I'd like to ask if your organization has done any work in exploring the feasibility of means testing and, if so, what are the practical difficulties in establishing income and asset tests that would determine eligibility?

Dr. SEAGRAVE. Yes, we have done some work, at least in the cost area, of looking at the options that are potentially available. First of all, I would not refer to it as means testing for the eligibility of medicare. The work that we have done has looked at the possibility of relating the SMI premiums, the deductibles, and coinsurance payments in both SMI and HI to income. There are a number of possibilities.

Perhaps the easiest and broadest source of income information at this point is through the income tax; and to the extent that that information could be used to relate some of these copayments to income, it would be, administratively, fairly simple. There are some problems with that, however. The income tax, first of all, does not cover all sources of income. It does not, in general, assess assets; and the information collected in the income tax is out of date in the sense that, of course, you pay your income tax, in general, in April for the previous year, and so there are problems with timelags between your income and the reporting of that income.

A more full means test would require moving in the direction of the means tests currently used today in the SSI, food stamp, or supplemental security income programs.

Senator GRASSLEY. One of the preliminary recommendations of the Advisory Council on Social Security is to raise the initial age of eligibility for medicare from 65 to 67, and I presume that recommendation followed on the decision of Congress, starting in the year 2000, to gradually raise the eligibility for social security. Although this change would not affect beneficiaries eligible for medicare on the basis of disability, how do you feel that this proposal would affect the elderly?

Perhaps the most important question connected with that is, who's going to provide health insurance to cover the 2-year gap?

Dr. SEAGRAVE. Yes.

I think the advisory council recommendation did tie in with their recommendation which, as you know, has since become law, that the retirement age for full benefits in the social security system increase from 65 to 67; and, indeed, that will start in the year 2000. I think the first answer to the question is the hope that retirement decisions will be postponed for a year or two; and that in that case, to the extent that people continue to work, they will have the health insurance that is associated with their employment. For those unable to work, presumably, there will be disability coverage which will continue as before. For a person between 65 and 67 years of age who is not working, it would be very expensive today to provide full health insurance coverage if they were to try and purchase that in the private market.

Senator GRASSLEY. Would you anticipate that the 65th and 66th years would be more expensive than the 64th year?

Dr. SEAGRAVE. I assume marginally more. Health expenditures are related to income.

Senator GRASSLEY. Let me clarify. I was talking about the affordability of the insurance. Would the insurance costs be more for those 2 years?

Dr. SEAGRAVE. Well, if you continued to work, I assume the insurance cost would be identical.

Senator GRASSLEY. OK.

Dr. SEAGRAVE. Because it would still be through your employer plan.

Senator GRASSLEY. That's my last question. I understand as we discussed previously on the plane, that you won't be able to stay for the entire hearing. I want to say you're welcome to stay as long as you can, and I appreciate your coming, and particularly the difficult period of time in getting here. Thank you very much.

Dr. SEAGRAVE. Thank you very much.

[Subsequent to the hearing, Senator Larry Pressler submitted questions in writing to Dr. Seagrave. Those questions and Dr. Seagrave's responses follow:]

Question 1. Many individuals in my State have expressed concern that the DRG prospective payment system could result in smaller hospitals being unable to compete in the areas of new technology and thus rural hospitals will become only minimal care facilities with major medical needs being met by a few large community hospitals. Further concern is expressed that this could eventually result in the closing of small hospitals and make access to care a severe problem.

Response. The Congress was concerned with the special problems that rural hospitals might face as a result of the DRG prospective payment system and built certain special exemptions into the system. Any hospital qualifying as a "sole community hospital" may use a special payment formula that reflects the special needs of that hospital. A "sole community hospital" is defined as a hospital that is the sole source of inpatient hospital services reasonably available to individuals in the immediate geographic area. Many small rural hospitals should qualify under this provision.

Question 2. You suggest in your testimony that tightening of reimbursements would run a substantial risk of reducing beneficiaries' access to quality care. Could you elaborate not only on the quality of care issue but some of CBO's predictions about access to care in rural areas?

Response. In my testimony, I did refer to a substantial risk of reducing beneficiaries' access to quality care, but only if the prospective reimbursement rates after 1985 are successively tightened. If the increased rates keep pace with the increasing costs of hospital inputs, the quality of care should not decline. In addition, as I have already discussed, special provisions have been included for certain rural hospitals with special needs.

Question 3. As a Senator from a rural State, I am also concerned about the effect that physician assignment could have on the number of physicians available in small town hospitals and clinics. The ability of small towns to attract and retain physicians has long been a problem. Has the Congressional Budget Office made any study of the impact that the possible reaction to mandatory assignment could have on this longstanding availability problem that our rural communities face?

Response. CBO has not studied possible effects of mandatory assignment on physician availability in rural communities. However, projected increases in the number of physicians should ease the problems of shortages in rural areas. The overall availability of physicians should dominate any impacts mandatory assignment might have in rural areas.

Senator GRASSLEY. Now we go to a series of panels in which we have two or three members who will speak in succession before I ask questions of the entire panel. We have invited to this first panel three individuals who are capable of providing us with diverse and independent perspectives of some of the problems that we're discussing here.

We have Dr. Gary Levitz. He is an assistant to the director of University of Iowa Hospitals and Clinics. Gary is filling in for John Colloton, who I've known for a long time, dating back to the time I was in the State legislature; John is director of the University of Iowa Hospitals and Clinics. We're pleased to have you here with us, Gary, and you're from Iowa City, I assume. Would you come up to the witness table?

Next we have Frank Severino substituting for Dr. Melvin Henderson, who, I regret to say, went in the ditch due to bad weather on his trip here, somewhere on Interstate 80. Hopefully you will communicate to him that I appreciate his loyalty in attempting to get here, but I'm particularly glad that you can substitute for him. I might say also, Frank, that I appreciate very much the many times you've been helpful to me in analyzing legislation and costs and alternatives to existing health care programs, particularly the way money can be saved.

And then we have Dr. Robert Pfaff of Dubuque, who I've known for a long time, because his wife, Marian, has been very active in Republican politics. Dr. Pfaff is president of the Iowa Foundation for Medical Care, which is Iowa's professional standards review organization. Dr. Pfaff's organization is a candidate to be the peer review organization under the new prospective reimbursement system which has taken effect.

We will proceed in the order that I introduced you, so it would be Gary, Frank, and then Dr. Pfaff. I would urge you, if possible to keep your statements to 7 minutes. Also, I've had an indication that some people are having difficulty hearing, so to the extent to which you can, speak up. I assume the microphones are on, it's just a case of talking into them.

Would you proceed, Gary?

STATEMENT DR. GARY S. LEVITZ, IOWA CITY, IOWA, ASSISTANT TO THE DIRECTOR, UNIVERSITY OF IOWA HOSPITALS AND CLINICS

Dr. LEVITZ. Thank you very much.

Because of a previous obligation, John Colloton could not be here for this hearing. He does, however, share with you and the others here today a deep personal concern for the crisis in medicare and proposals for its reform. Mr. Colloton sends his warmest personal regards to you, Senator, and is very appreciative of your efforts in this area, and has asked me to express his sincere interest in working with you and your committee as you grapple with this problem.

The needs of academic health centers and teaching hospitals are of special concern to those of us who serve at the University of Iowa Hospitals and Clinics, and these concerns will be specifically addressed in my remarks today. Let me begin with comments on the prospective payment system, which will have a major impact on hospitals across the country, and has serious implications for teaching hospitals and academic health centers, and raises a number of concerns.

The first of these concerns is the recognition of teaching hospital's societal contributions. Colleges of medicine and teaching hospitals are the producers of multiple products that benefit not only the individual patient but society as a whole. These products include graduate medical and other health science education, new technology testing, clinical research, substantial amounts of charity care, highly specialized services, and extensive ambulatory care programs operating on a subsidized basis, resulting in higher costs that most be reflected in teaching hospital patient charges.

As a supplement to the basic DRG payment, Congress provided for the continued payment of direct educational costs, consisting largely of house staff stipends, but including nursing and allied program costs on a passthrough basis. Second, based on a recognition of the disadvantaged position of teaching hospitals under the DRG system, the Congress arbitrarily increased the indirect educational cost factor now paid in medicare rates.

Without the indirect educational cost adjustment and continued participation by the medicare program in payment for educational programs, teaching hospitals would have major difficulty in maintaining highly sophisticated patient services and teaching programs for the training of residents and the replenishment of health personnel essential to the staffing of our community delivery systems in future years. This is a key area that needs resolution during the implementation of the payment system.

At the present time, the DRG's themselves do not contain an adjustment for severity of illness. This is another problem. Inclusion of a severity adjustment in future DRG payments is of significant importance to tertiary care referral centers. It is expected that teaching hospitals may treat a patient case mix containing a high volume of more severely ill rather than less severely ill patients within DRG's and will face great difficulty, without some kind of adjustment for the severity of illness of these patients. Leaders in academic health centers and university teaching hospitals are appreciative of the congressional recognition of the severity-of-illness issue as part of the indirect educational cost adjustment and believe this adjustment must be maintained until a severity-of-illness adjustment is incorporated into the DRG system.

Another concern focuses on continued support of technology. The medicare program has allowed only a 1-percent adjustment under TEFRA, and beginning on October 1, 1986, any new technology required or acquired by a hospital must be covered in the DRG rate. With this major downward adjustment in payments for new technology, Government has begun to limit the future growth and development of the health care system. While I am in agreement that unnecessary duplication of services must be avoided, caution is advised in applying an arbitrary standard in an effort to reduce duplication in costs that may also thwart technological advances which will ultimately benefit our citizens.

During the next several years, as a result of the enabling legislation, studies will be conducted by the Secretary of Health and Human Services and a 15-member Prospective Payment Assessment Commission appointed by the Director of the Office of Technology Assessment. We feel fortunate, not only in teaching hospitals, but in Iowa, that on November 19, 1983, John W. Colloton was appointed as a member of the Prospective Payment Assessment Commission.

In the prepared statement, a number of medicare reforms are discussed and critiqued, so I will not go into an in-depth discussion at this time. After examining the impact of reforms which increase beneficiary cost sharing, you are encouraged to assess the extent to which increased levels of cost sharing diversely affect medicare recipients. It is expected that the poor elderly would be especially hard hit, and those elderly already covered by medicaid would have these costs transferred to the States, which are similarly experiencing financing dilemmas.

In assessing the potential of freezing medicare physician payment levels for 1 year, we believe that the adoption of this reform may severely limit access to physician services on the part of medicare beneficiaries. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to hold down physician reimbursements. By 1981, average reimbursable charges were 32 percent lower than actual submitted charges. To cope with inflationary costs, physicians may choose not to accept assignments but instead to bill medicare beneficiaries for any additional charges. Unfortunately, this may result in the development of a two-class system of care.

One reform proposal would make the receipt of medicare benefits conditional upon income or some other measure of economic resources. Means testing is open to criticism because it will change the underlying philosophy of the medicare program, currently a social insurance program.

Clearly, while the problem of the medicare trust fund needs to be addressed in the immediate future, the solution adopted will have a profound impact on the integrity of the present health care delivery system. The medicare program is but one element in the medical care marketplace, and any reforms adopted for medicare must take into account other diverse components involved.

At the national level, there is a need for an equitable financing mechanism for health care that guarantees access to quality health services for all Americans and the maintenance of our teaching and patient care initiatives. The real problem before us today is to establish a framework through which we may collectively develop an effective and efficient mechanism to plan, provide, and pay for health services and educational programs. The prime responsibility for the leadership essential to the establishment of such a Federal health policy rests with the executive branch and the Congress. A national policy on health care service financing reform is long overdue and critically needed to lend direction, unity, and success to this system.

In conclusion, the establishment of a basic principle that calls for all payers to pay their proportionate share of caring for the poor and aged until a national policy is enacted is critically needed at this juncture. I am hopeful that under the auspices of a major national foundation, a voluntary group composed of leaders from health delivery organizations, business, labor, insurance, and government, will take the lead in insuring that the Nation adheres to this principle and thereby meets its obligation to serve the poor and aged patients during the transition period leading to the establishment of a national policy for the financing of health care.

I thank you for this opportunity and welcome your questions later.

Senator GRASSLEY. Thank you, Gary. The prepared statement of John Colloton will be inserted into the record at this point.

[The statement of Mr. Colloton follows:]

HEARING SPONSORED BY THE UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

ON

"THE CRISIS IN MEDICARE: PROPOSALS FOR REFORM"

Testimony of

John W. Colloton

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and Assistant to the University President for Statewide Health Services

(Presented by Gary S. Levitz, Ph.D., Assistant to the Director
University of Iowa Hospitals and Clinics)

Sioux City, Iowa
November 11, 1983

Mr. Chairman, I thank you for this opportunity to testify on an important subject, The Crisis in Medicare and Proposals for Reform. The importance of the Medicare program for this country's older citizens cannot be overstated. It is the primary means of financing the health care services they require. The impact of the impending deficit in the Medicare Hospital Insurance Trust Fund is real and concerns us all, and we must take planned and measured steps, taking into account the long range interests of the American people, to maintain the solvency of this exceedingly important fund.

At the same time that our Medicare program approaches a funding crisis, the health care system in this country is under seige. Changes are occurring at a rapid pace, and the instability of the system has many of my colleagues and me concerned about our ability to continue to provide the high quality single class system of care we have striven to achieve. Prospective payment by Medicare, and in Iowa also by Blue Cross and Medicaid, leaves us with many unanswered questions for the future financing and delivery of health services. Increased competition from HMO's, PPO's and business coalitions seeking low cost providers raises concern centering on access to care for our poor, underserved and older citizens. Controls on the acquisition of new resources through regulatory programs such as certificate of need, rate review and utilization review, raise questions about our ability to maintain health care research programs to improve technology and service and to maintain the diverse educational programs essential to replenish quality health personnel. The challenge before us is clear. Providers, consumers, business, labor, government, and other third party payers must work together to effect reasoned change in the financing of the health care delivery system to assure health providers can continue to provide humanistic health services in an economically efficient manner. The interests of the government and other payers to contain costs must be balanced with these considerations and the need to maintain a health delivery system in which access to quality health care services is assured for all of our citizens.

In my discussion I will provide some background on the funding, size, and utilization of services in the Medicare program, review issues with regard to the Prospective Payment System, and comment on current proposals for reform. The needs of academic health centers and teaching hospitals are of special concern to me and will be specifically addressed in my remarks. My conclusion will include a recommendation for the establishment of a voluntary group representative of all participants in the health care industry, supported by a major national foundation, to address the long range issue of health care financing.

I. Background

We are addressing the issue of the crisis in Medicare financing because of the increasingly high cost of providing health care to Americans in general, and to the recipients of Federal health care programs in particular. An examination of the projected increase in national health care expenditures gives us a clear picture of the magnitude of the health care financing problem.(1)

U.S. Health Care Expenditures

National Health Expenditures (NHE) in 1981 were $286.6 billion, an average of $1,225 per person. As Table 1 below indicates, public funds contributed 42.7% or $122.5 billion dollars.(2)

Table 1
U.S. Health Care Expenditures
Total, U.S. (1981)

	Dollars (In billions)	Percent
Public	122.5	42.7
Private	164.1	57.3
Total, U.S.	286.6	100.0

In 1965, NHE comprised 6% of the Gross National Product. Over the years, this proportion has increased to where in 1981 it was 9.8%. By 1983, the health care sector share of the Gross National Product is projected to increase to about 10.4%. Projections made by the Health Care Financing Administration indicate national health expenditures will reach $456 billion in 1985, and $756 billion by 1990. Per capita expenditures will be $1,882 in 1985, representing a 54% increase over the 1981 figure of $1,225. In 1990, the per capita expenditure is anticipated to be $2,982. The Health Resource Administration estimates that the costs of illness will exceed $2 trillion by the year 2000.

Personal Health Care Expenditures (PHCE) totalled $255 billion in 1981, of which the Federal government contributed 29%, or $74.6 billion. Table 2 below provides data on personal health care expenditures.(3)

Table 2
U.S. Total Personal Health Care Expenditures
(excludes expense of prepayment, administration and government public health activities, 1981)

	Dollars (In Billions)	Percent
Total, U.S. (1981)	255.0	100.00
Total, Government	102.9	40.00
State & Local	28.3	11.00
Federal	74.6	29.00
Total, Non-government	152.0	60.00
Philanthropy	3.5	1.00
Private Health Insurance	66.8	26.00
Direct Payment	81.7	32.00

A rapid growth in Medicare outlays has also occurred since fiscal year 1967, when the program began paying for health services to our elderly citizens. In that year, total expenses were $3.4 billion for 19.1 million enrollees. Today, the growth of the program is reflected in the fact that 1983 outlays are expected to total $57.4 billion for 29 million enrollees and, by 1988, the

Congressional Budget Office has projected that outlays will approach $112 billion.(4)

Concern over the structure of Medicare benefits is reflected in the projection that total public spending for health care is expected to reach $325 billion by 1990, of which the Federal government will finance approximately 70%.(5)

Per Capita Costs:

When total per capita cost of health care is contrasted with the government's share of these costs, we find that the government's contribution to the Total Systems Cost per Capita* has changed dramatically over the past 30 years. Today, and in the future, the government can be expected to be a major participant in the financing of health care, as the data in Table 3 indicates.

Table 3
Total Systems Cost Per Capita

	Per Capita Cost	Federal Governmental Share
1965............	$ 181	13%
1981............	1090	29
1983............	1359	30
1985............	1683	30
1990............	2701	30

* Total Systems Cost/Capita includes all medical care costs related to direct patient care whether out-of-pocket or insured.

Role of Medicare in Financing Health Care

In examining Medicare's performance in covering health care expenses for the elderly, it is noteworthy that program reimbursements account for less than one-half of the medical care costs experienced by the elderly. In large part, this is due to the fact that the elderly's medical expenditures are concentrated on non-acute services, such as nursing home care, which are not comprehensively covered by Medicare.

Medicare now provides an estimated 44% of all health care expenditures by the elderly.(6) Medicaid contributes about an additional 14% to financing the health care of Medicare recipients.(7) Individual out-of-pocket payments, private health insurance, and aid from charitable organizations provide for 36% of the expenses.(8) Although Medicare does help to meet a significant portion of the costs of health care, individuals face additional out-of-pocket expenses resulting from cost-sharing and gaps in coverage.

- Individual Liability: It is important to recognize that medical expenses affect the elderly differentially, depending on their income. The Congressional Budget Office projects that by 1984, non-institutionalized persons with household incomes under $5,000 will have medical expenditures totalling 97% of their $3,659 average income, 18% of which they must pay out-of-pocket.(9) At the other income extreme, those in the highest income category are expected to have expenditures representing less than 5% of their projected average income of $58,306 and will pay just over 1% out-of-pocket.(10) Medicare cost sharing for elderly non-institutionalized enrollees is projected to average $457 in 1984, of which about $76 will be paid by someone other than the enrollee,(11) generally through supplemental insurance or Medicaid. Three-quarters of the enrollees will incur cost sharing amounts of less than $500,(12) and 2% of all elderly enrollees will experience Medicare cost sharing expenses in excess of $2,000. The availability of Medicaid and private insurance coverage protects about 75% of the high users of Medicare from extraordinary individual liability.(13)
- Range of Benefits: While Medicare has apparently been successful in covering the acute care needs of the elderly and disabled, it has been criticized for failing to provide a fully comprehensive range of medical

services. In 1978, Medicare paid 69% of the hospital and physician expenses of the elderly but, as mentioned, only 44% of their total health expenditures.(14) Although in 1978 nursing home care accounted for 1/4 of the total health care expenditures of the elderly, Medicare reimbursement paid only 3% of all of the elderly's nursing home care expenses.(15) This is attributable to the fact that Medicare's nursing home benefit is restricted to acute care needs in skilled nursing facilities. However, even if nursing home expenses are excluded, Medicare would pay only 58% of all other expenses.(16) Other exclusions from the program are outpatient drugs and dental services which represented 9.3% of the elderly's total medical care expenditures in 1978.(17)

II. Perceptions of Problems with Health Care Financing

The Medicare program exists in an environment in which a number of factors have, and will continue to have an impact on health care costs. These factors create problems in the design and financing of Medicare.

The rising costs of health are due in part to:

- General Inflation, which accounted for approximately 57% of the increase in total system cost (Personal health care cost) in the period 1971-1981, is the most important factor contributing to the growth in expenditures. Lowering inflation rates in the future would not substantially reduce aggregate health costs, but would constrain the rate of increase.
- Third Party Financing programs, whose very structure increases the demand for health care and incorporates cost-increasing incentives, are important contributors to the cost spiral. Tax subsidies which provide incentives to purchase more coverage have encouraged this growth and are, to some degree, responsible for increased costs. Consumers have demanded

more and better health insurance coverage, and, as we have decreased individual financial responsibility for health care, we have not incorporated appropriate incentives to control demand.

- Cost-Based Reimbursement which is the way in which some major third party payers reimburse providers has also drawn criticism because of built-in incentives to increase costs. Retrospective cost-based reimbursement for hospitals encourages utilization by providing more revenue for higher utilization levels. Although new reimbursement mechanisms are being implemented, continued investigation into the effects of reversing these "cost-increasing" incentives is warranted.
- Population Characteristics such as increases in real income and the growing numbers of aging citizens and increases in real income will also escalate demand and need for services.
- Technological Advances which emanate from the $3 billion annual commitment of National Institutes of Health for research toward new treatment, techniques, equipment, and services aimed at improving the health status of our citizens.

In summary, the rising costs of health care are putting pressure on the elderly to pay a greater share of their health care costs in the future. The elderly, however, are currently participating in the financing of the Medicare program through cost-sharing mechanisms such as co-payments and deductibles. Many elderly purchase supplemental insurance to cover the "gaps" in Medicare coverage. Any increases in cost-sharing will doubtlessly have a negative impact on many. In addition, the restricted range of providers and covered services result in further out-of-pocket expenses which the elderly must bear. A reform strategy placing limits on reimbursement to providers may result in the elderly experiencing greater economic and access problems. Therefore, before any changes are made in the benefit structure, we should achieve an understanding of the impact of proposed alternatives on access and utilization, on the elderly's health care expenses, and on the financial status of providers. The following sections will attempt to contribute to this understanding by analyzing the impact of prospective payment, current reform proposals, and some recommendations for modifications in the program.

III. Impact of Prospective Payment on Hospitals

The newly enacted Medicare legislation establishing a system of paying hospitals a prospectively determined fixed price based on the classification of patients into Diagnosis Related Groups or DRGs will have a major impact on hospitals across the country, and has serious implications for teaching hospitals. This new prospective payment system represents a profound change from the cost-based reimbursement system, utilized by the Medicare program since its inception. Instead of being reimbursed on the basis of actual costs incurred, all hospitals will now have incentives to develop efficient and effective methods of producing health services and to provide these services to patients within the specific payment level for each DRG.

The logic of this system is clear. The Medicare program now has established a methodology which will enable its administrators to predict its costs based on the historical diagnoses reported for patients covered by the Medicare system. Because of the expected major deficits in the Medicare Hospital Insurance Trust Fund, Congress and the Health Care Financing Administration will no doubt be carefully reviewing the prospective payment rates, and seeking every possible method to reduce those rates to the absolute minimum. There are several concerns, the resolution of which can have serious implications for academic health centers and teaching hospitals.

Recognition of Societal Contributions

The DRGs do not now include the costs incurred by teaching hospitals in producing a broad array of societal goods, beyond the care provided to patients with complex clinical problems. These special societal contributions are not fully reflected in an "average" cost per case across the nation's 6,000 short term acute hospitals, of which teaching hospitals comprise a small group.

Colleges of medicine and teaching hospitals are the producers of multiple products that benefit not only the individual patient, but society as a whole. These products include graduate medical and other health science education, new technology testing, clinical research, substantial amounts of charity care, highly specialized services, and extensive ambulatory care programs operating on a subsidized basis. Generation of these multiple products, which are termed "societal contributions," necessarily results in higher costs that must be reflected in teaching hospital patient charges. Obviously, the teaching hospital payment under the DRG system, if it is to be equitable to sustain the generation of these societal contributions, must be differentiated from that paid to a community hospital which does not incur these costs. Fortunately, this need, to a certain extent, has been recognized by Congress, as I will later describe.

To gain an appreciation for the magnitude of total costs involved in providing these societal contributions, the University of Iowa Hospitals, in 1981, conducted a survey of the 270 Council of Teaching Hospital members, with major college of medicine affiliations. Some of the resulting data, which was originally used in a paper on competition for the Duke University Private Sector Conference in 1981, is presented on the series of appended exhibits, numbers I through III.(18)

In the aggregate, as can be visualized on Exhibit I, in fiscal 1981 the financial needs of these 270 major teaching hospitals totalled some $20.2 70% of the total, while the additional societal contributions totaled $6.1 billion. Basic patient care services accounted for $14.1 billion or a full 30% of the total financial needs of these 270 COTH members.

The composition of these societal contributions and the costs associated with each are delineated in Exhibit II. They are divided into two basic groups. The first group, on the right, includes graduate medical, dental, and other health science educational programs with direct costs of $1.2 billion; ambulatory care program deficits at a cost of $340 million; and large scale charity care at a cost of $1.7 billion. The aggregate cost of these programs in 1981 was $3.2 billion.

The second group of societal contributions, shown on the left, includes clinical research support, new technology testing, and highly specialized services and intensive case mix at an aggregate cost of $2.9 billion during 1981. Because the cost of these latter programs is not directly measurable, this figure was derived through a somewhat complex formula based on the per diem differential between the 270 COTH members and all other non-federal acute general hospitals, after factoring out the cost of measurable societal contributions.

Obviously, a DRG payment that is calculated on the basis of average costs across virtually all of the nation's 6,000 acute general hospitals will not accommodate a sizeable portion of the $6.1 billion costs in providing these societal contributions.

The Future of the Education Adjustments

So what did Congress offer in recognition of these unique needs of teaching hospitals? First, as a supplement to the basic DRG payment, it provided for continued payment of direct educational costs, consisting largely of house staff stipends, but including nursing and allied health program costs, on a "passthrough" basis. This payment, of approximately $384 million by Medicare, when coupled with an assumed full payment by other payers of their proportionate share of direct educational costs, would cover $1.2 billion or approximately 20% of the $6.1 billion aggregate cost of the societal contributions. Secondly, based on a recognition of the disadvantaged position of teaching hospitals under the DRG system, the Congress arbitrarily increased the indirect educational cost factor now paid in Medicare rates with the following explanation:

> "This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching institutions."(19)

The indirect educational cost adjustment, which is a percentage increase in each teaching hospital's DRG payment based on the number of resident physicians per bed, will add approximately $1.3 billion to aggregate teaching hospital Medicare payments under the DRG system. Because the Medicare portion of societal contribution costs for which the indirect educational cost adjustment is serving as a proxy payment is approximately $1.6 billion, the 270 teaching hospitals develop a shortfall in payment for these particular costs of some $320 million based on 1981 costs of all societal contributions through the direct and indirect educational adjustments. This information is summarized in Exhibit III.

Performance of Evaluation Studies

In the establishment of this far reaching legislation, Congress recognized the need to evaluate the changes and their impact on the health care system. This evaluative effort will be critical to the success of the prospective payment system, and the ability of our nation's hospitals to maintain the high level of quality which our citizens have come to expect and deserve. Congress must carefully monitor the studies to be conducted by the Health Care Financing Administration (Exhibit IV) and those to be conducted by the Prospective Payment Assessment Commission. Each of these evaluations should be of high quality, and serve to lead and direct providers to more effective delivery of humanistic health care. Several elements to be studied are of significant importance to hospitals such as the University of Iowa Hospitals and Clinics, and I will reference these critical elements here.

- Severity of Illness: At the present time, the DRGs, themselves, do not contain an adjustment for severity of illness. This problem is addressed through proxy by the indirect educational cost adjustment. Inclusion of a severity adjustment in future DRG payments is of significant importance to tertiary care referral centers. In order to effectively operate under the DRG prospective payment system, a hospital must have a volume of patients who require services below the average required for other patients in that DRG to offset the greater costs of patients who require services with costs above the average. If a hospital's case mix is such that it can provide services to patients less severely ill in a significant number of cases, that hospital will be able to make money on the DRG system. Hospitals which treat a patient case mix which contains a high volume of more severely ill patients will face great difficulty without some kind of adjustment for severity. Continued evaluation of severity of illness methodologies and their applicability to a DRG payment system should be encouraged by the Congress. Leaders in academic health centers and university teaching hospitals are appreciative of the Congressional recognition of the severity of illness issue as part of the indirect educational cost adjustment, and believe this adjustment must be maintained until a severity of illness adjustment is incorporated into the DRG system.

- Indirect Educational Cost Adjustment: Despite its relationship to the higher costs experienced in teaching institutions, we believe that this educational cost adjustment is in potential jeopardy because it is out in the open without a solid formula to continue justification of its existence. In addition, the Social Security Advisory Council has recommended a review of the Medicare program's continued participation in payment for educational programs. This critical point will be evaluated and debated over the months and years ahead, and a major study by Arthur Young and Company should shed light on the productivity and activities of house staff physician trainees in teaching hospitals. Without the indirect educational cost adjustment and continued participation by the Medicare program in payment for educational programs, teaching hospitals would have major difficulty in maintaining highly sophisticated patient services, teaching programs for the training of residents, and the replenishment of health manpower.
- Technology Growth: One of the elements which has made America's health care system the best in the world is the fact that we have expended the dollars required to improve our technology and extend our knowledge base in order to advance the scope and quality of health services for our citizens. Society is now entering an era in which it will carefully judge the resources required for new patient care services and technology development. The Medicare program has allowed only a 1% adjustment for

new technology under TEFRA, and beginning on October 1, 1986 any new technology required or acquired by a hospital must be covered in the DRG rate. With this major downward adjustment in payment for new technology, government has begun to limit the future growth and development of the health care system. The result of this decision should be carefully evaluated. While we are in agreement that unnecessary duplication of services should be avoided, caution is advised in applying an arbitrary standard in an effort to reduce duplication that may also thwart technological advances which will ultimately benefit our citizens.

- Patterns of Practice and Referrals: The establishment of a DRG payment based on an average will encourage modification in physicians' patterns of practice. In Iowa, as an example, providers have established, through years of voluntary effort, a stratified health care system among primary and secondary hospitals with reliance on the University of Iowa Hospitals and Clinics as their statewide tertiary health center. The impact of prospective payment on these longstanding relationships cannot be determined at this time, but the long range effects on changes in referral patterns should be studied to avoid compounding problems in the future.
- Outliers: The definition of outlier cases will have a significant impact on teaching hospitals, as these hospitals have and will continue to accept more complex and resource intensive patients. In the experimental program in New Jersey, approximately 30% of the patients cared for in the system were classified as outliers. In the Medicare prospective payment system only 5% to 6% of all payments will be made for those patients designated as outliers. The impact of including a fair measure of expensive patients as outliers should be evaluated during the implementation of the payment program.

Cost Shifting Due to Contractual Obligations, Charity and Bad Debt

A difference exists between the actual cost of treating a Medicare patient adnd the reimbursement the provider receives from the Medicare program. This debate over cost shifting is intensifying as the prospective payment system begins. While the government has responded that it is a prudent purchaser, paying hospitals only for the costs associated with serving government beneficiaries, this stand will force some hospitals to shift unpaid "common costs" to charge paying private insurers. In many areas, other purchasers have also negotiated discounts from the standard rates being paid by commercial insurers. Many of these purchasers have argued that they should not have to pay the bad debt incurred for any group of patients other than their own. However, the costs of providing health care to the uninsured remains a bad debt that must be paid from some source, and remains a significant concern of all providers.

The Health Insurance Association of America has indicated that cost shifting, the differential between the Medicare rate and payment covered by insurance companies, grew from an average of $12 per day in 1975 to an estimated $50 per adjusted day in 1980.(20) The magnitude of this problem is also evidenced in data provided by the Association of American Medical Colleges. Council of Teaching Hospitals institutions reported that in 1981 deductions from revenue for contractural obligations amounted to 10.6%; bad debt 5.1%; charity 1.7%; and other 0.8%. This results in a total differential of 18.2% between the cost and charge payers.

At the same time some payers are paying less than full charges, other payers and businesses are reacting to what they perceive to be an inequitable situation. As an example of the impact of contractural obligations on full charge payers, Caterpillar, Inc., reported that cost-shifting accounted for $12 million of the $77 million that it paid last year to U.S. hospitals.(21) This represents a differential of 16% and is in line with the data reported above. The issue of who will pay for the uninsured patient needs to be addressed in any discussion of health care financing.

Several options for reform of the Medicare program have been proposed by the Administration, Congress, Congressional Budget Office, and others. The implementation of Medicare's prospective payment system can be viewed as the first step in what providers of health care expect to be a series of reforms, which I will review and comment on in the following section.

IV. Current Reform Proposals

The Reagan Administration has proposed a number of Medicare reforms which are intended to ensure the continued fiscal viability of the Health Insurance Trust Fund. These reforms are based on the assumption that the behavior of hospitals, physicians, consumers, employers, and insurers can be favorably altered by eliminating the "perverse incentives" inherent in the cost based reimbursement system. Delineated below are the major characteristics of each of the Administration's proposed reforms and some of the problems which may be associated with their implementation. The reforms which will be discussed are: restructuring Medicare hospital cost sharing and catastrophic coverage; issuing voluntary vouchers; freezing physician's fee payment levels for one year; increasing the Medicare Part B premium; indexing the part B deductible to the Medicare economic index; deferring beneficiary liability for cost sharing until death; and means-testing.

Restructuring Medicare Cost Sharing And Hospital Catastrophic Coverage

One proposal being considered by the Senate Finance Committee provides for the restructuring of beneficiary Medicare Part A cost sharing (cost shifting to the patient) and provision of catastrophic coverage. The beneficiary currently is assessed a $350 first day deductible for hospitalization through the 60th day, $87.50 per day beginning with the 61st through the 90th day, $175 per day for the 91st through the 150th day and thereafter the days are not covered by Medicare. The Administration's proposal is compared and summarized with the present situation in Table 4.

Table 4

Comparison of Beneficiary Liability Under Current Law Versus Proposed Law

	1984	
	Current Law	Proposed Law
Hospital Spell of Illness:		
Day 1	$350.00	$350.00*
Days 2-15	0	$28.00/day or 8% of $350
Days 16-60	0	$17.50/day or 5% of $350
Days 61-90	$87.50/day	0
Days 91-150	$175.00/day	0
Days 151 +	Not Covered**	0
Skilled Nursing Facility:		
Days 1-20	0	0
Days 21 +	$43.75/day	$17.50/day or 5% of $350

*Not to be assessed more than twice per year.
**Except for 60 lifetime reserve days.

As can be seen, the proposed law dramatically increases the beneficiary's liability (cost sharing) for presumably less catastrophic hospitalizations (under 60 days) and at the same time provides total coverage for the infrequent, more extended hospitalizations. On balance, though, most of the aged would experience higher out-of-pocket costs if such a proposal were implemented. Those individuals who are hospitalized, which constitute 23% of the 29 million enrollees, would face higher hospital payments. As an example, an eight day stay would be associated with an additional $196 co-payment over existing levels. The poor elderly would be especially hard hit, and those elderly already covered by Medicaid would have these costs transferred to the states, which are similarly experiencing financing dilemmas. Further, since the most senior beneficiaries have higher rates of hospitalization, this group would be the most negatively affected by these elevated out-of-pocket costs.

Optional Medicare Voucher

The optional voucher provision builds on current law by allowing Medicare beneficiaries to use Medicare benefits to enroll in a wider array of private health plans. Under such a plan, Medicare would contribute an amount equal to 95% of what it would have cost to care for the beneficiary under traditional Medicare coverage. Enrollment in a private health plan would be voluntary, but if a beneficiary selects a plan whose cost is less than the Medicare's contribution, the beneficiary would receive a cash rebate. Those beneficiaries selecting a private health plan that cost more than Medicare's contribution would be required to make up the difference from their own funds. Under the optional voucher program, beneficiaries would annually be allowed to switch private health plans or elect to obtain traditional Medicare coverage. The program would further mandate that an acceptable private health plan must cover the services provided under Parts A and B in Medicare and must participate in a coordinated annual open enrollment period.

The voucher approach transfers the responsibility to consumers to select an appropriate health plan and, when necessary, to submit the voucher for payment to their chosen provider. The consumer must select a provider who will accept the voucher for full payment of covered services. The whole approach is based on the assumption that the patient is able to make informed decisions about his/her own health care. However, in the medical care market place, this is not generally the case. Further, presumably only certain providers will accept the vouchers and these may not be the patient's first choice provider. Thus, while vouchers may, in the short run, assist in controlling system costs, they would do little to address our primary concerns of patient satisfaction and quality of care.

Additionally, we cannot be sure that vouchers will indeed decrease total program costs. Private plans typically experience higher administrative costs than the Medicare Program and thus, may render them more expensive. Moreover, if a voucher system were enacted, individuals may rationally choose to remain in the traditional Medicare Program if they assess themselves to be at risk of future hospitalization. This unresolved problem of adverse selection may, in fact, increase total program costs for Medicare.

Freeze Medicare Physician Payment Levels For One Year

The Administration proposes to freeze Medicare's physician fee payment levels for 1984 at 1983 levels. Adoption of this reform may severely limit access to physician services on the part of Medicare beneficiaries. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to hold down physician reimbursements. By 1981, average reimburseable charges were 32% lower than actual submitted charges.[22] While freezing Medicare physician payment levels is projected to save close to $800 million by the end of FY84, it should be noted that physician payment levels have been constrained since 1976. To cope with inflationary costs, physicians may choose not to accept assignment, but instead decide to bill Medicare beneficiaries for any additional charges. Unfortunately, this may result in the development of a two class system of care.

Increase Medicare Part B Payment in Stages

The primary features of the proposal for cost sharing provide for increasing the patient's liability for Part B premiums to 25% of the projected expenditures beginning January 1, 1984, and to further increase this proportionally 2.5% per year until it reaches 35% on January 1, 1988. The current premium of $12.20 per month would be maintained until the end of the current year. If in 1984 the premium were set at 35% of the projected expenditures, the premium charged would be $20. As a result, beneficiary costs would increase, an average, $68 per year. By incrementally increasing the premiums and deductibles which beneficiaries will individually be required to pay, the Medicare program will be reducing its share of support for the elderly's health care to much lower levels than at present. This reform, however, would not affect current levels of utilization. The poor, though, would be especially disadvantaged under such a system because the costs would be evenly spread across all recipients.

Index Part B Deductible To The Medicare Economic Index

The Administration proposes to index the Part B deductible to the annual changes in the National Medicare Economic Index. This provision would maintain the constant dollar value of the deductible. Current law does not provide for regular increases in the deductible to reflect increases in health care costs. The Administration believes that the reduction in the dollar value of the deductible has resulted in its not serving as a deterrent to utilization, as was its initial intent. The deductible will continue to be applied to all individuals regardless of income. As a result, it will impact differentially across income groups.

Between 1967 and 1980 the deductible rose from $50 to $75 while Supplementary Medical Insurance reimbursements grew 328%. Increasing the deductible to $100 on January 1, 1984 and indexing it to the rate of growth per capita would raise average Medicare cost-sharing by about $13 in calendar year 1984.[23] Seventy percent of the beneficiaries currently exceed the deductible and this group would be required to pay the additional costs of the deductible. While this is a minimal yearly cost experienced by all beneficiaries, the ability to pay among those in the low income groups not also covered by Medicaid should be further evaluated.

Deferring Beneficiary Liability for Cost Sharing Until Death

Rather than increasing direct patient cash outlays for deductibles, coinsurance or other forms of cost sharing, some consideration has been given by the Congressional Budget Office to Medicare obtaining payment from the beneficiary's estate at time of death. Such deferral would extend until after the death of the spouse and any dependents. We believe that such a program would make payment too remote to the actual health service for which the liability was incurred. Additionally, in too many cases the patient and family members would not be perceptive to the fact that liabilities against them are being incurred.

Means-Testing For Receipt of Benefits

The Congressional Budget Office has made a reform proposal which would make the receipt of benefits conditional upon income (or some other measure of economic resources). As Medicare benefits are not currently means tested, structuring benefits differentially for persons at various levels of income or resources would represent a major philosophical shift in the program. Currently the payment of benefits to the aged and disabled far exceed the actuarial value of their contributions to the system. An elderly couple reaching age 65 in 1982, of whom one spouse had average covered earnings over the 1966-1982 period, would have paid in $2,200. The present value of their future lifetime benefit is projected to be $63,000 -- 28.6 times their actual contribution.[24]

Means-testing could be used to moderate the impact of health care costs on those with modest incomes. As an example, co-insurance levels could be adjusted by income. Means testing can be criticized because it will change the underlying philosophy of the Medicare Program, currently a social insurance program. The use of means testing would transform the program into an eligibility program. Additionally, there are practical problems associated with implementing means testing. These include the need to define measures appropriately and develop a viable structure to apply a means test. Administrative problems would involve defining resources, measuring resources, and establishing a structure for the means test. The establishment of a structure for the means test would involve determining what cut-off points would be used to determine dollar levels below which benefits would be available and above which they would not be. Medicare is a program our older citizens have come to rely upon as they approach retirement, and to change the basic philosophy of the program would be an issue of immense political and social debate.

Summary

In summary, cost sharing approaches need to be investigated further before their widespread adoption. Cost sharing does reduce demand, and lower levels of health status may result if cost sharing served as a deterrent to the utilization of needed care.

Catastrophic coverage under Medicare Part A has been offered in tandem to the cost sharing approach. However, depending on the out-of-pocket limit established, relatively few people would benefit from catastrophic coverage.

with a coinsurance that would be 10 percent of the deductible amount, 5 percent of the enrollees would be subject to a limit of $2,000. The average increase for those whose cost-sharing rises would be $389.[25] Additionally, catastrophic coverage would not cover the expenses of non-hospital providers such as physicians or mental health facilities.

It may be noteworthy to at least identify several other approaches to Medicare expenditure cost cutting which are being suggested. One approach is to regulate hospital revenue. While this approach may be seemingly attractive, difficulties arise because ethical decisions would need to be made regarding who is treated and what methods of treatment would be used. Increasing price competition among providers by giving employees multiple choice of different plans has also been suggested as an option to function in concert with employee fixed-payment contributions to health plans.

Clearly, while the problem of the Medicare Trust Fund needs to be addressed in the immediate future, the solution adopted will have a profound impact on the integrity of the present health care delivery system.

V. Conclusion and Recommendations

The options just discussed are under consideration because of the need to address the financial viability of the Health Insurance Trust Fund. It appears that the adoption of some combination of the alternatives will assist in placing expenditures more in balance with revenues. However, the challenges and problems faced by Congress in attempting to finance a health program are not unique, and the selection from among a number of alternatives is not without consequence.

Perhaps, however, the biggest problem before us is to resist the temptation to adopt a strategy of short run initiatives designed to gain immediate results, overlooking the complexity of the situation before us which calls for the adoption of a long-range strategy. Clearly, this nation has yet to find an appropriate answer to the question of how to pay for health care. Throughout history we have adopted payment schemes tailored to fit the problems then at hand. In 1983, the most pressing problem is cost, and the nation is clearly in a state of transition with respect to the issue of how to finance health care. The Medicare program is but one element in the medical care marketplace, and any reforms adopted for Medicare must take into account the relationships among the other diverse components involved. Health care costs will continue to increase because of factors related to inflation, population growth including a significantly enlarged aged population, the expanding base of biomedical knowledge, and the inherent characteristics of the current health care delivery system. In response to the present overriding concern with cost, we may expect representatives of each of the major groups with an interest in health care delivery (payers, providers, consumers, federal and state governments, business, and labor) to continue to advocate positions based on short-run self-interest rather than on maintaining and further refining the overall integrity of the health care delivery system. Hence, these individual pressures taken collectively, do add a heightened immediacy to the current problem.

A number of currently occurring events indicate that this is the case. Third-party payers are negotiating preferred provider agreements and discounts on a broad scale. Leaders of business are encouraging the development of business-health coalitions, preferred provider organizations, and alternative delivery systems. Medicaid programs across the country are establishing prospective payment systems with varying degrees of sophistication and fiscal responsibility to patients protected by the program. The federal government is emphasizing its role as a prudent purchaser by holding the line on payment and providing incentives for the development of alternative delivery systems, some of which restrict the choice of provider. Hospitals are engaging in large-scale "cost transfer" practices to cover the "shortfalls" in individual payment plans which is resulting in state and federal legislative proposals to ban this practice. In the short run, and by applying one prime criterion, namely cost containment, these various approaches may have some degree of success. However, these efforts do not address the overall problem which is to equitably reform the financing of the nation's health care system.

The national need is for an equitable financing mechanism for health care that assures access to quality health services for all Americans and the maintenance of our teaching and patient care initiatives. The real problem before us today is to establish a framework through which we may collectively develop an effective and efficient mechanism to plan, provide, and pay for health services and educational programs. The prime responsibility for the leadership essential to the establishment of such a federal health policy rests with the Executive Branch and the Congress. A national policy on health care financing reform is long overdue and critically needed to lend direction, unity and success to this system.

Until such policy is developed and implemented, this nation will continue to be in a state of transition during which individual payers will negotiate the best possible arrangements for their particular constituencies with little or no consideration of the whole. Concomitantly, the means of financing health care for the poor and others who are unable to pay is going unattended, and, as a result is leading to the reestablishment of a two-class patient care system and barriers to care for the poor and some aged. This is a phenomenon unworthy of our society, especially in the 1980's.

The establishment of a basic principle that calls for all payers to pay their proportionate share of the costs of caring for the poor and aged until a national policy is enacted is critically needed at this juncture. I am hopeful that under the auspices of a major national foundation a voluntary group, composed of leaders from health delivery organizations, business, labor, insurance and government, will take the lead in assuring that the nation adheres to this principle and thereby meets its obligation to serve the poor and underserved patients during the transition period leading to the establishment of a national policy for the financing of health care.

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10. Ibid., p. 21.

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12. Ibid., p. 28.

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18. Colloton, John W. "An Analysis of Proposed Competitive Health System Plans and the Implications for Teaching Hospitals." Paper presented to the Sixth Private Sector Conference, Duke University Medical Center, Durham, North Carolina, March 23, 1981. As published in Financing Health Care: Competition Versus Regulation. Duncan Yaggy and William G. Anylan (Eds.). Cambridge, Mass.: Ballinger Publishing Co., 1982.

19. U. S. Congress. Senate Report 98-23, p. 52.

20. Health Insurance Association of America. "Source Book of Health Insurance Data: 1982-1983". Washington, D.C.: Health Insurance Association of America, 1983. p. 43.

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22. Davis, C.K. Testimony Before the Special Committee on Aging, United States Senate, The Future of Medicare, April 13, 1983: p. 33.

23. U. S. Congress. "Changing the Structure of Medicare Benefits." p. 49.

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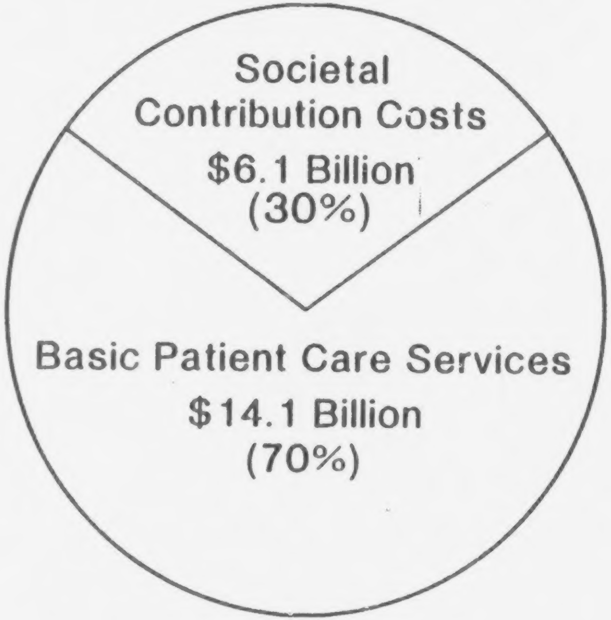
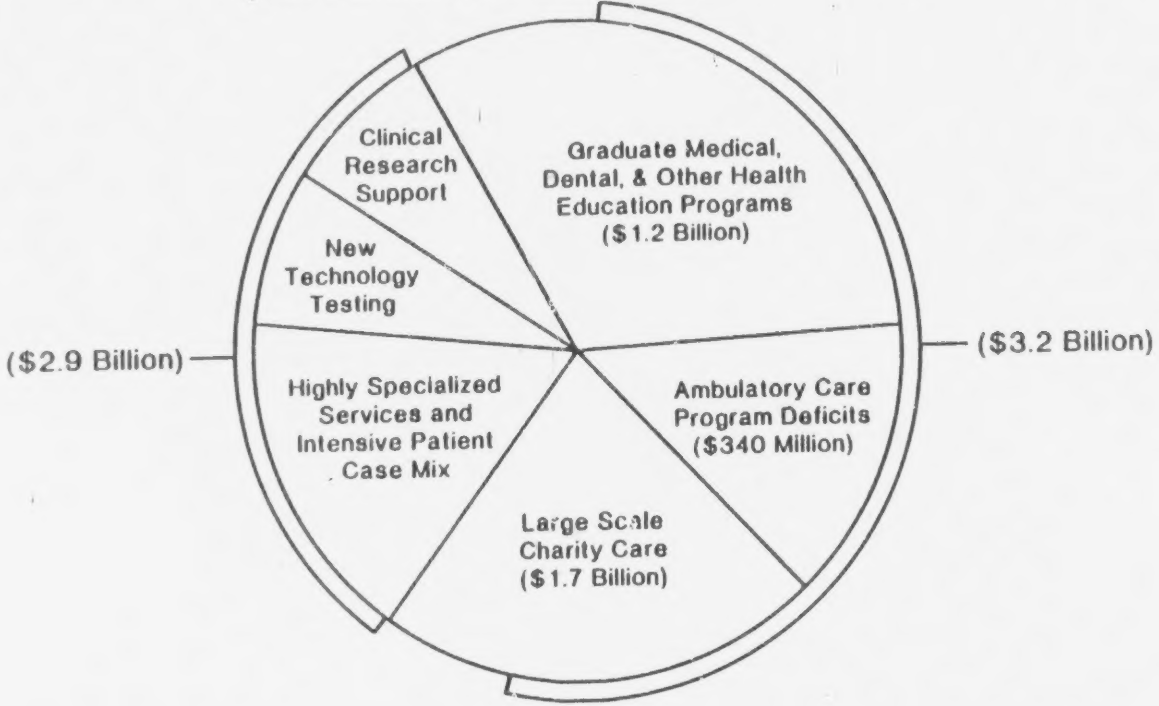
FINANCIAL NEEDS OF 270 COTH MEMBERS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

(projected from Iowa Survey data of 20 university owned COTH members)
($20.2 Billion-Fiscal 1981)



SOCIETAL CONTRIBUTIONS OF TEACHING HOSPITALS
($6.1 Billion Annual Cost-Fiscal 1981)



ESTIMATED COSTS AND PAYMENTS FOR SOCIETAL CONTRIBUTIONS OF 270 COTH MEMBERS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS UNDER MEDICARE DRG PAYMENT SYSTEM

(MILLIONS OF 1981 DOLLARS)

Societal Contribution Payment Element	Total Cost	Medicare Portion (32%)		Other Payors Portion (68%)		Shortfall
		Cost	Payment	Cost	Payment	
● Direct Educational Cost-Based Payment	$1,200	$ 384	$ 384	$ 816	$ 816	$ 0
● Indirect Educational Cost Payment - Proxy for all other societal contributions	4,922	1,575	1,255*	3,347	3,347**	(320)
TOTAL	$6,122	$1,959	$1,639	$4,163	$4,163	($320)

*Estimated on the basis of the 1981 study of 270 COTH Hospitals by the University of Iowa Hospitals & Clinics and additional data from the COTH Directory.

**Assumes full payment by "other payors" and no shifting of Medicare indirect education cost shortfall to payors.

Exhibit III

SELECTED STUDIES OF DRG SYSTEM TO BE CONDUCTED BY HHS SECRETARY UNDER SEC. 603 OF THE SOCIAL SECURITY AMENDMENTS OF 1983

- IMPACT OF DRG PAYMENT METHODOLOGY (ANNUALLY)
- INCLUSION OF CAPITAL-RELATED COSTS IN DRG PAYMENTS (DUE 1984)
- DRG-BASED PAYMENTS TO PHYSICIANS (DUE 1985)
- INCLUSION OF SEVERITY OF ILLNESS FACTOR (DUE 1985)
- COST SHIFTING AND EXTENSION OF DRG SYSTEM TO ALL PAYORS (DUE 1985)
- APPROPRIATE ADJUSTMENTS FOR UNCOMPENSATED CARE COSTS (DUE 1985)
- APPROPRIATE ADJUSTMENTS FOR LARGE TEACHING HOSPITALS IN RURAL AREAS (DUE 1985)

Senator **Grassley**. Please proceed, Frank.

STATEMENT OF FRANK SEVERINO, HEALTH POLICY CORP. OF IOWA, DES MOINES, IOWA

Mr. **Severino**. I'll try to synopsize Dr. Henderson's remarks today. I'm going to skip the problem in the future, which we've already covered, and try to really cut right into what we see are the issues.

I think there's a lack of confidence in the traditional delivery and financing of health care. Although the historic and projected problems may suggest the need for pumping more money into the medicare system, much evidence suggests that the existing system of delivery and financing does not use resources wisely. Prices charged to medicare vary substantially from hospital to hospital in Iowa. I was just looking at the new Governor's commission report that was just issued yesterday. For Woodbury County versus Plymouth County, the numbers look something like this: 1,195 for Woodbury, 791 for Plymouth, Cherokee 849, Ida 818.

Iowa has a high rate of hospital admissions. It's the No. 1 problem coming out of the Governor's commission report. It is also quite variable from county to county, as I pointed out. Twenty-four Iowa counties had admission rates below 400 admissions per 1,000 enrollees; the rates for 20 counties are above 500 per 1,000 enrollees.

Senator **Grassley**. And those are the figures you were referring to there for those four or five counties?

Mr. **Severino**. Yes, sir.

This wide variation in admissions also manifests itself in a wide variation of costs for persons enrolled in medicaid. Hospital—part A—costs per enrollee varied substantially in Iowa again in 1981. Residents in 41 counties had medicaid costs of less than $700 per enrollee. However, 20 counties had costs of more than $900 per person. The range was $513 to $1,211 per enrollee.

Well, some of the solutions that we think ought to be looked at: Medicare must support payment systems which provide incentives to doctors and hospitals to reduce inpatient utilization. The new DRG system is a step in the right direction. It will help hospitals define and price their output; it should encourage shorter lengths of stay and more cost—effective use of ancillary services and reduce duplication services. Attention also must be paid to the provision of long-term health care services for the elderly which are community or home based, and move away from medically oriented case models.

We're rapidly approaching medicalizing the long-term care industry in this country. An assessment program is needed for the elderly to determine the appropriate level and mix of services to meet their long-term care needs.

As you well know, Senator, we've established the data commission, which is unprecedented in this country as far as identifying best-value doctors and hospitals; and I submit to you, across the country the single most important ingredient that's missing in this equation is data, and accurate data. And it's interesting to us in our corporation that we cannot determine who the medicare physicians are, under the present guidelines, that are delivering care in Iowa. We can find out with our data commission the rest of the physicians and what they're doing and the prices they're charging, but under the medicare system we're unable to.

Well, there's some drawbacks to DRG, and I'd like to point out two. While DRG offers a means for improving the health care system, it also has disadvantages. By paying hospitals a fixed price, an incentive may exist to admit more cases which are less costly than others and only exacerbate the admissions problem. Two, in addition, the new DRG may result in more cost shifting to third-party payers. It is crucial that Iowa hospitals reduce their budget increases to levels more in line with the general rate of inflation. Our corporation is about to take on a study to try to measure the cost shifting in the State of Iowa at the present time.

Reference all-payer systems, the Health Policy Corp. believes that all payers should exercise leverage as prudent payers of health care, thereby increasing the efficiency and effectiveness of the health care system. Health Policy Corp. does not support all-payer rate review systems, which have not been proven to reduce costs. In all-payer rate review operations, purchasers and providers lose their role in shaping the health care system. That system ends up being directed by a bureaucracy which does not reflect the wishes, the ideas or direction of the players involved—the payers, providers and purchasers of health care.

Thank you, sir.

Senator GRASSLEY. Thank you. I am going to put Dr. Henderson's paper into the record at this point.

[The paper referred to follows:]

MEDICARE IN IOWA: Problems and Prospects

I. PROBLEMS

A. Historic

*Nationally, the Medicare budget has been doubling every four to five years.

*While some of this has been due to increases in the general rate of inflation, increases in medical prices have been running at 1½ to 2 times the general rate.

*For example, Iowa Medicare costs per Medicare enrollee have increased from $377 in 1974 to $953 in 1980, a 153% increase.

*Out-of-pocket health care expenditures for the nation's elderly also have been spiraling. One national study suggests that payments for health care services made directly by the aged patients themselves rose from $234 to $390 per capita from 1966 to 1975, an increase in the same proportion as that of the consumer price index. Health care costs rose so quickly that Medicare did not succeed in reducing the real burden of health care costs on those 65 and older.

*Part of the increase in out-of-pocket costs is allocated for payment of premiums on the "Medi-gap" insurance. Premiums for this type of coverage have been increasing rapidly, placing the protection beyond the financial grasp of many elderly.

*Hospital acute care costs are a key culprit facing Medicare. The program cannot continue financing a medically-oriented model for long-term health services which focuses strictly on acute care. Medicare must begin to address long-term care services available in alternative settings outside the acute care environment.

*As Medicare places restrictions on its payments to physicians, fewer physicians have been accepting the reimbursement on an assignment basis.

*We are becoming increasingly aware of the dilemma confronting the Medicare entitlement program. We have promised a large segment of the population services which we no longer seem to be willing to provide or pay more taxes to support.

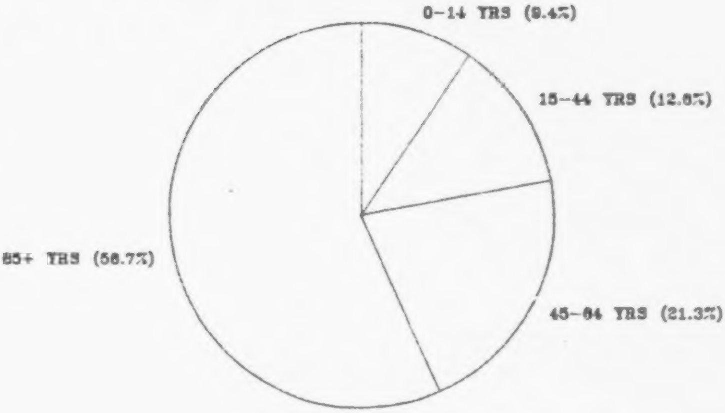
B. FUTURE

*The numbers of persons needing Medicare coverage are rapidly increasing. In Iowa, every eighth Iowan now is over age 65; by 2020, every fifth resident will be 65+.

*Older Iowans also need more health care than younger citizens; studies show those 65+ go to the hospital twice as much and stay twice as long as do persons under 65.

Iowa Inpatient Days

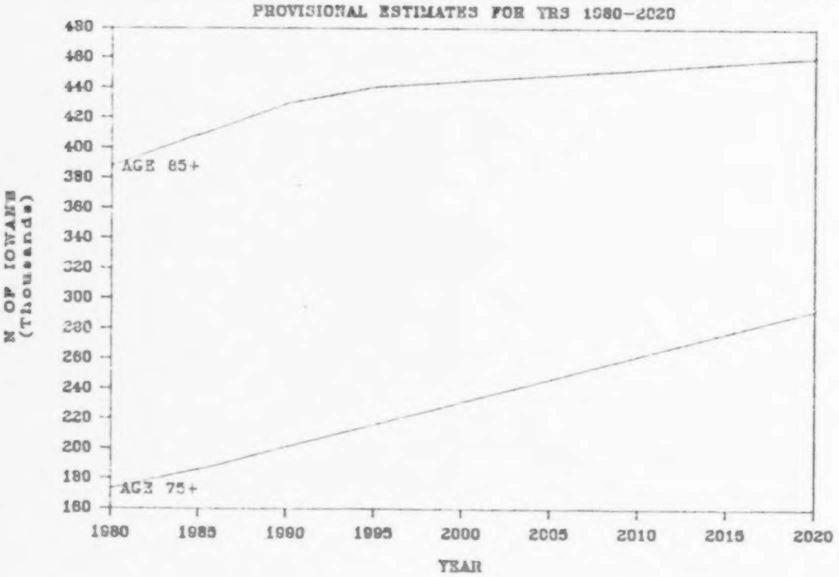
by Age (1980)



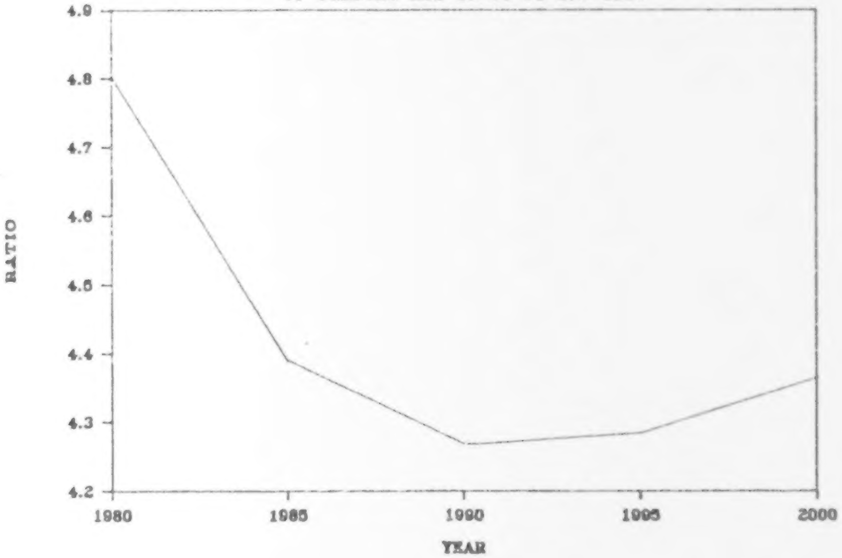
*By the year 2000, Iowa's 65 group will grow to 15% of the total population, and the 75+ group will make up 52% of the older Iowans.

PROJECTIONS OF IOWANS AGED 65+ & 75+

PROVISIONAL ESTIMATES FOR YRS 1980-2020



*While Iowa's elderly population grows, there will be fewer and fewer young people who work to provide the tax revenue for Medicare programs. Between now and 2000, there will be four working-age people for each person over 65. However, the declining birth rate and the numbers of young people leaving the state will reduce the ratio to only 3 persons per Medicare recipient. This ratio will place a greater burden on a shrinking work force and a smaller tax base.



Medicare Dependency Ratio 1978 - 2000

OF PERSONS AGE 15-64 TO 65+ YRS.

*The reserves in the Medicare trust fund are disappearing at an alarming rate; it is projected by analysts who study the Medicare system that the fund will be bankrupt by 1990 - just seven years away.

*A few months ago, it was proposed that the current payroll tax now supporting Medicare be doubled as one way to postpone the bankruptcy until 1995.

*There are tremendous variations in the numbers of admissions, numbers of patient days and average lengths of stay for the elderly across the country. It has been shown that quality care can be delivered in fewer numbers of days.

*LACK OF CONFIDENCE IN THE TRADITIONAL DELIVERY AND FINANCING SYSTEMS

-Although the historic and projected problems may suggest the need for pumping more money into the Medicare system, much evidence suggests that the existing system of delivery and financing does not use resources wisely.

-Prices charged to Medicare vary substantially from hospital to hospital in Iowa.

-As indicated previously, Iowa has a high rate of hospital admissions. It is also quite variable from county to county. Twenty-four Iowa counties had admissions rates below 400 admissions per 1000 enrollees; the rates for 20 counties are above 500 per 1000 enrollees.

-This wide variation in admissions also manifests itself in a wide variation of costs for persons enrolled in Medicaid. Hospital (Part A) costs per enrollee varied substantially in Iowa again in 1981. Residents in 41 Iowa counties had Medicaid costs of less than $700 per enrollee. However, 20 counties had costs of more than $900 per person. The range was $513 to $1,211 per enrollee.

II. SOLUTIONS

*Medicare must support payment systems which provide incentives to doctors and hospitals to reduce inpatient use and increase services in alternative settings (such as outpatient departments), and must also explore capitation payment programs.

*The new DRG system is a step in the right direction for achieving this. It will help hospitals define and price their output; it should encourage shorter lengths of stay and more cost-effective use of ancillary service, and reduce duplication of service.

*Attention also must be paid to the provision of long-term health care services for the elderly which are community or home-based, in a move away from the medically-oriented care model.

*An assessment program is needed for the elderly to determine the appropriate level and mix of service to meet their long-term care needs.

III. DRAWBACKS

*While the DRG system offers a means for improving the health care system, it also has disadvantages. By paying hospitals a fixed price, an incentive may exist to admit more cases which are less costly than others and only exacerbate the admissions problem.

*In addition, the new DRG system may result in more cost-shifting to third-party payers. It is crucial that Iowa hospitals reduce their budget increases to levels more in line with the general rate of inflation.

IV. ALL PAYER SYSTEMS

HPCI believes that all payers should exercise leverage as prudent payers of health care, thereby increasing the efficiency and effectiveness of the health care system.

It does not support all-payer rate review systems, which have not been proven to reduce costs. In all-payer rate review operations, purchasers and providers lose their role in shaping the health care system. That system ends up being directed by a bureaucracy which does not reflect the wishes, ideas or direction of the players involved--the payers, provider and purchasers.

R. Melvin Hnderson
Health Policy Corporation
of Iowa
November 11, 1983

Senator **Grassley**. Dr. Pfaff.

STATEMENT OF DR. ROBERT A. PFAFF, WEST DES MOINES, IOWA, PRESIDENT, IOWA FEDERATION FOR MEDICAL CARE

Dr. **Pfaff**. Senator Grassley, I am Robert A. Pfaff. I am a physician practicing urology in Dubuque. I am also president of the Iowa Foundation for Medical Care. The Iowa Foundation was established in the early seventies as Iowa's physician peer review organization, and today over 2,000 Iowa physicians are members.

We appreciate your invitation to participate in this hearing.

The foundation, which has been Iowa's PSRO since 1972, is the largest medical review organization in the Nation, doing both public and private utilization and quality review. Our review covers medicare and medicaid patients, privately insured patients, and freestanding surgical centers. The Governor's Commission on Health Care Costs has endorsed the Iowa foundation as Iowa's medical-peer-review organization and has recommended it continue as the State's main coordinator for utilization review. We are a candidate to become Iowa's professional review organization; and the authors of the legislation used the foundation as, partially, a model in framing their proposed legislation.

We've done utilization and quality review retrospectively and concurrently; and now we've added the prospective-payment system based on the diagnosis-related groups to our review program. Our primary concern as a physician organization has always been the high quality of medical care; and we have proved that high-quality medical care and cost-effective medical care can go hand in hand.

Our data show that we have reduced days of care per 1,000 in four of our major review areas without a concomitant reduction in the quality of care. A comparison of January through July 1982 and 1983 shows medicare days of care down 7.1 percent, medicaid days of care down 4.2 percent, Blue Cross/Blue Shield of Iowa down 7 percent, and John Deere & Co. down 3.4 percent.

Although we have no direct control over health-care reimbursement for medicare, we believe that two points must be made part of any legislation that deals with the elderly. The first is physician review of health-care services. The second is adoption of a program that covers a variety of options in health care for the elderly and is not necessarily limited to admission to hospitals or residency in long-term care facilities.

Physician peer review is essential to insure that attempts to reduce health-care costs do not compromise quality of care. Decisions about whether a patient should be admitted to a facility or whether the patient should stay once he or she is admitted should be made only by physicians.

Until the prospective-payment system, medical review organizations like the Iowa foundation were primarily involved in reviewing utilization to insure patients didn't stay too long in the hospital. Under PPS, physicians must do utilization review to insure patients stay in the hospital as long as they are required to. PPS incentives to save money could mean that some patients may be discharged from hospitals while they still need acute care. We must be sure that this does not happen.

Effective health care for the elderly can be delivered in many settings beyond hospitals and long-term care facilities. The lack of skilled nursing beds is a problem in Iowa, which generally has too many acute-care beds and not enough skilled-care beds to help support our elderly rural population.

Although the availability of skilled beds would allow early discharge from acute beds to lower level care, strict interpretation of medicare criteria and inadequate reimbursement for skilled care are roadblocks in developing an adequate number of skilled-care beds. Some skilled-care patients are being cared for in intermediate-care facilities which are reimbursed under medicaid, but patients who require a good deal of care—although they don't need acute care—are difficult to place. Medicare does not pay for ICF care.

Most of Iowa's small hospitals are in rural areas with large elderly populations. In many instances, patients don't need acute care; they need skilled care which is not available. An expanded, adequately reimbursed swing-bed program would go far to help alleviate that problem and would undoubtedly show a cost savings over paying for only acute-care beds that patients may not need.

We believe that small hospitals must be given incentives to provide various levels of care, such as centers for outpatient and diagnostic testing services, as well as skilled beds to meet the rural communities' health-care needs.

Iowa relies heavily on institutional settings for delivering long-term-care services, even though the majority of older Iowans remain in their communities. Although nursing hospitals deliver efficient long-term care to people who need 24-hour inpatient services, Iowa's need and the Nation's need for community-based care must also be recognized and addressed.

Public expenditures for nursing home care in Iowa nearly tripled from 1974 to 1979. Only 7 percent of Iowans over age 65 live in nursing homes, but they account for 84 percent of public expenditures for long-term care services. Resources are concentrated in intermediate-level-nursing-home care, for which medicaid paid $90 million in 1980. During the same time, public expenditures allocated $4 million for skilled-nursing-home care, $4 million for residential-level care, $12 million for home health care, $800,000 for adult day health care, and $9 million for support services such as meals and transportation. Although family members don't generally relinquish their caregiving roles until they reach a crisis in caring for elderly relatives, there is little support for families who care for aging family members. Families provide about 80 percent of all care for members who need assistance, and they give about $287 monthly in services for every $120 spent by agencies.

Lack of community-based care, lack of reimbursement for community-based care, lack of skilled beds, lack of comprehensive assessments upon which to base placement decisions mean that Iowa's intermediate-care beds are 93-percent occupied today, even though the State has more such beds than it needs. Iowa has 10.6 intermediate beds for every 1,000 adult Iowans. Data suggests that about 2.8 adult-care beds in every 1,000 will take care of that level of care.

Noninstitutional long-term-care services are funded by multiple programs and agencies at the Federal, State, and the local levels. No single agency has overall responsibility. Separate eligibility requirements, benefit packages, provider restrictions, administrative structures, and delivery mechanisms have created a seriously fragmented system.

Insuring the availability of appropriate quality health care for this Nation's elderly must be a priority for this country, and it is a priority that physicians and organizations like the Iowa Foundation for Medical Care can help meet.

Senator GRASSLEY. Thank you very much.

It was at this point that I know Senator Pressler had hoped to be here, because he was interested in asking about the problems of rural hospitals. I want to say for the record that this a concern of his, in case he is unable to show up because of the weather.

Well, here is Senator Pressler now. Larry, you couldn't have come at a better time. Do you want to get your breath?

I'll proceed with some questions. We've had two witnesses, and this is the first panel. I was just stating that you had an interest in rural hospitals and wanted to ask some questions along that line. I was going to ask some questions in that area, but, while you're getting your breath, I'll ask some questions concerning another issue.

I want to ask about the implementation of the new prospective-payment system, because we all know that this represents a dramatic change in the current reimbursement policy. What pitfalls do we need to keep a particularly watchful eye on? I would ask each of you to comment. Utilization review has been one helpful technique in Iowa. Do you see an expanded role for such reviews, especially in the area of preadmission screening?

I would direct that second question to you, Dr. Pfaff, because you've done a lot of work in that area. Perhaps the others can fill in with some additional ideas they have.

Please go ahead.

Dr. PFAFF. There's no question that the institution of prospective payment and the DRG system is going to increase our role considerably in the business of utilization review as well as quality review. We are at present just setting up, with only seven hospitals in the State of Iowa so far having gone into the prospective-payment system. The rest will have gone in by next summer. I would feel that it's very definitely a fact that our reviews are going to increase—they will have to—and I'm sure that there's going to be preadmission screening of some sort.

At present, we are working on a system of a focused review. In other words, on the basis of our data regarding every physician in the State, any physician who has a greater than a 2.5 percent inappropriate admission rate for hospitals will have a focused review of all his admissions for a period of time, and if that proves to be of no particular—if it proves that, in fact, he is not admitting inappropriately, then that will be dropped for him.

Senator GRASSLEY. Gary or Frank, do you have anything you want to add to that?

Mr. SEVERINO. No, sir.

Senator GRASSLEY. OK.

Congress needs to explore a vast array of options, as I've said so many times, in resolving this medicare crisis. One broad area which deserves careful scrutiny is that of alternative systems of care and delivery. We're hearing a great deal about home health care as a potential method to provide quality care in what we would hope would be a comfortable environment and at a lower cost. Congress is also seeing some efforts to utilize alternative providers of care, such as physicians' assistants and CRNA's to constrain costs.

In your view, what impact on the quality of care would such expanded coverage have? Could you start off, Gary?

Dr. LEVITZ. The use of alternative delivery systems does hold promise. However, there are some problems and drawbacks which we need to be concerned with. Clearly, in Iowa, as Dr. Pfaff has indicated, there is a problem in long-term-care placement. Some of this might be resolved by the use of home-health-care programs and other community-based programs. However, we need to be concerned with the quality, the monitoring of the services that are provided, who provides the services, and of, course, the reimbursement of these services; and on a long-term basis, studies have shown really mixed results as to whether or not, from other areas of the country, these programs are successful in holding down overall community costs, because we do find that new eligible recipients enter these programs once the benefit is given.

The use of physicians' assistants and aides, nursing aides, likewise would have to be monitored, and the program would have to be developed and phased in so we can evaluate the impact of this alternative.

Senator GRASSLEY. I would also like to ask, what's your opinion of medicare coverage of alternative health and medical services?

Dr. LEVITZ. My understanding right now is that the medicare program contributes very little to skilled nursing services and to long-term care services. It was developed as an acute-care program. The services that are provided are based on an episode of illness that's acute. Up until recently, one had to be admitted to a short-term hospital in order to be eligible for limited skilled nursing benefits. As a result, many of the alternatives to institutional care have not been funded through the medicare program. We find these being funded by the medicaid program in many States once individuals spend down their assets and become eligible.

Senator GRASSLEY. Dr. Pfaff.

Do you have anything to add?

Dr. PFAFF. I have nothing else to add.

Senator GRASSLEY. OK. Frank.

Mr. SEVERINO. No, sir.

Senator GRASSLEY. I want to just penetrate and probe a little further. Am I to conclude from the lack of endorsement of medicare coverage for alternative health and medical services that there's a reluctance to move in that direction?

Mr. SEVERINO. I think the real dilemma is we just don't know.

Senator GRASSLEY. OK.

So you don't really have a position, because of lack of knowledge?

Mr. SEVERINO. And information.

Senator GRASSLEY. Dr. Pfaff.

Dr. PFAFF. You speak of alternative delivery systems. I am a member of an HMO in Dubuque, and we have recently gone into a medicare HMO program that appears to be very well and enthusiastically accepted by a lot of elderly citizens around Dubuque. We haven't been in it long enough to have very definite and mature judgments, frankly.

Dr. LEVITZ. And also, as you mentioned earlier, one of the problems that we have in rural States in the delivery of health care is the geographic dispersion of the population. Health maintenance organizations perhaps might be successful in cities of the size of Dubuque, because you have the critical mass of individuals who can join. You also have a mass of individuals who join the plan but do not really make use of the plan, hence subsidizing the costs of those individuals who are most likely to get sick.

In rural areas, it may be more difficult to set up alternative delivery systems because of the problems of distance and traveltime. As an example, in many areas of other States of which I'm familiar, home health programs have difficulty because the standard reimbursement does not take into account traveltime involved. So, in a city, a home health agency might be able to stagger visits in such a way that many occur within a three- or four-block area. On a county level, in determining what may be needed for the reimbursement of a home health agency—we may find that the distances involved in getting from one visit to another may be greater timewise than the actual time involved in providing the services that are required.

Senator GRASSLEY. Frank, in Dr. Henderson's testimony, he stressed the need to appropriately allocate scarce resources. I guess that's what your job is really all about. If you view available resources and dollars as something fixed, it is your contention that we need to pursue to a greater extent capitation programs, which may even include physician fee schedules?

Mr. SEVERINO. Yes, sir.

Through a Robert Wood Johnson grant, we are piloting in Iowa a capitation project, and that will be something that we'll be experimenting with in the next 18 months, to see how effective that is and what kind of reception we get, from a participation standpoint, on it.

Senator GRASSLEY. Before I turn over the questioning to Senator Pressler, I want to introduce my distinguished colleague, Senator Pressler, to everybody here.

Senator Pressler and I were elected to Congress in the same year. He moved over to the Senate 2 years before I did. I've known him for 9 or 10 years now, and know him to be very devoted to ferreting out grassroots opinion in his State. He spends a great deal of time at meetings like this. Even though it's across the river from his State, his appearance here today isn't a surprise to any of us who know Larry Pressler. He also is a member of the Senate Special Committee on Aging.

I would defer to you, now, for any opening statement that you would like to make, and please proceed with any questions that you'd like to ask this panel.

STATEMENT BY SENATOR LARRY PRESSLER

Senator **Pressler**. Well, thank you very much, Senator Grassley. I commend you for holding this hearing, because there is nothing more important right now than looking at some of the problems with medicare. Indeed, by 1990, as you have probably pointed out, we will face a real crisis with this program. As a member of both the Finance and Aging Committees, you will find yourself in the middle of trying to reform—if that's the right word—medicare, because what's happening is that our entire system is spending far more than it's taking in. Health costs are continually rising.

I have introduced legislation which would set up a bipartisan commission similar to the one we had for social security. I'm not really a commission type in the sense that I think those of us who are elected to the Senate and the House have to make the final decisions, but the commission concept seemed to work with social security. And now we're faced with the same kind of business of cutting spending or increasing taxes in order to solve the problems with medicare as we did with social security. These are difficult decisions, to put it mildly.

Also, in this part of the country, where we are not so heavily populated, the problems of hospitals and nursing homes with 40 beds or less, are unique. Not to mention the bigger ones which also have problems—but I imagine in Iowa you have a lot of hospitals that are 40 beds or less. We certainly do in South Dakota. We have a lot of nursing homes of that size.

But that's not really the only problem, but it is a critical question. That's why it's important to have this hearing in Sioux City, Iowa. It represents a forum for rural concerns. Our chairman, Senator Heinz, and I recently had a hearing in a 900-bed nursing facility, if you can believe that, in New York City. When you have 900 beds, you have enough volume that you can hire more people and you can average things out so the DRG prospective payment system works out. But there is a big difference between the administration of a 900-bed hospital and a 40-bed hospital. The administrator with 40 can't average things out as the Washington planners think he should be able to.

Mr. Chairman, I want to apologize for being late. I'm running about 4 hours late today, and I was just informed that we're going to drive rather than fly to the next destination of the day, so I'm going to have to leave fairly soon. I do want to make an opening statement.

I planned to spend 3½ hours here today, but something has got to give. This is difficult for me when my staff has gone to so much work, as has your staff.

I want to commend your staff, incidentally, in preparing very careful questions. I've read much of this. One thing I did get done was reading a lot of the prepared statements for today's hearing, because I spent a lot of time in airplanes. I won't take you through all that. Later today, I'm going to be serving on a Rhodes scholarship selection board, and I've got to get to another city for that. So somebody is going to be mad at me before the day is over. I'm going to take one thing at a time and do the best I can.

Let me say at the onset that there is no problem facing Congress that's going to be more painful than the subject we're dealing with today. It involves health care. The average person's medical bills in the last 6 months of their lives are greater than the total bills for the rest of their life. We do try to preserve human life and we place a high value on it, and that's why we have so much trouble when one of our Americans gets killed in Lebanon or some far corner of this world. No society in the world places a higher value on life. We've made that decision and, of course, it's a very expensive decision.

It is clear to those of us in Congress that without changing the system the hospital insurance trust fund will be depleted by 1990. I think we have to act responsibly and tell people the truth about some of these problems, because we're going to have to act on it not in 1991, but now. That's the purpose of this hearing, to lay the groundwork.

While we have made changes in our payment method, questions about the effect that the prospective reimbursement system may have on the quality of care remain unanswered. Many of our constituents have expressed concern—as this panel has—about the new medicare DRG reimbursement plan and the fact that it will impose serious consequences on their access to care. If our small rural communities lose their hospitals, the long distances that their citizens will have to travel may become a major problem.

I might say that in the 900-bed New York nursing home that I was in, they liked the DRG plan very much, so that's the problem that Senator Grassley and I face all the time. It's urban versus rural. I'm not talking about small cities. I'm talking about the great cities in our land, which have their place, but so much of this legislation is tailored to the big city, and it's a constant struggle to get it tailored so it fits both. Changes in the physician reimbursement and benefit structures must be considered very carefully, because they have a staggering impact on rural areas.

Let me say that I think your questions have covered some of my prepared questions, but I did read the statements, and I would like to ask Dr. Pfaff a question, if I may. Someone else may take up on it also, because I want to cover it a little bit more.

Comments similar to yours have been made at other Aging Committee hearings in South Dakota and elsewhere. The nursing home industry representatives indicated at some of these hearings that one of the problems with the prospective reimbursement system which we must be prepared to face is the early dismissal of patients in need of skilled nursing home care which is not going to be available for them.

Now, true, I'm all for home health care and visiting nurses, and so forth, but there are some patients who need the help of an institution. Could you elaborate on what you foresee as the best solution to this problem?

And you've done some of that already, but you seem to indicate in your statement that an expanded swing-bed program could best alleviate the problem.

Could you expand on that statement and give some illustrations on the cost savings you predict?

Dr. Pfaff. I think the swing-bed program as it's been worked out is one of the bright lights so far as rural America is concerned. I think that having a bed that can be used at the place where it's most—where it's going to do the most good is a very practical idea. There may be times when there are enough acute-care patients that those swing beds should be put into acute-care activities. There may be other times when, rather than just let them sit, they can be used for nursing home activities.

I think that there are some restrictions on the size of the hospitals, and so forth, but I do believe that some of these restrictions could well be removed so that more small hospitals can have access to this: It's practical.

Senator Pressler. Now, how would this work, for example, in cost factors?

Could you give an example of how that would work? How much would they cost, and how much would be saved by, let's say, a 40-bed hospital?

Dr. Pfaff. I don't have an answer for you. I don't have any figures, no.

Senator Pressler. But it's a concept——

Dr. Pfaff. Just coming off the top of my head. And the Iowa Foundation has nothing to do with the figures that have come up regarding use of swing beds. I'm sure the fiscal intermediary would have all the answers on that. I don't.

Senator Pressler. OK.

I might ask Mr. Severino—who is substituting, I understand, for Dr. Melvin Henderson—I read Dr. Henderson's statement. I believe you have already done this to some extent, but could you elaborate on the problems with the DRG prospective payment problem that you mentioned? How would you propose we deal with the problem of early dismissals of patients in need of skilled nursing, but for whom nursing home beds are not available?

For example, the all-payer review systems are being discussed as alternatives in many of the Eastern States. Could you tell us more about way you feel these systems would be inappropriate with all the players involved—the payers, providers, and purchasers? And if you covered this before I came in the room, why——

Mr. Severino. No, I haven't.

One of the things we feel strongly about is an all-payer rate review system. In the regulated States—Maryland, New Jersey, Massachusetts—what we think that does is lock in what we see as a bloat in the acute-care system as it stands today, and particularly in Iowa, the excess capacity. What we do, then, is lock that in when we go to an all-payer rate review system.

There's several disadvantages to all payer. First of all, there's no incentive for the physicians to be more efficient. We talked about the bloat. Anytime we go to an all payer, a commission-type system—we've seen it with the certificate-of-need program where the providers actually capture, if you will, that system and maneuver it to their best advantage. And I can go on and on, where we've weighed the advantages and disadvantages.

In Iowa we are on a track—and by the way, Senator, we see this as our agenda for the eighties in Iowa. It's a Governor's commission report that we keep updating. There's 77 recommendations in there, and we're through 12 of them. We would like to, in Iowa, to stay on this competitive model and the Governor's commission report before we even consider going to a rate-regulated system, and we need time to do that; and the timeframe that we're looking at is from 3 to 5 years to give us an opportunity to provide data to consumers, to look at what the system should be in the future. Eighty percent of the expenditures of health care in Iowa are in large multihospital communities.

OK. When we dream of what the hospital of the future should be in smalltown Iowa, we ought to open our vision a little bit, so maybe it shouldn't be all that it is today to the community; and if you could just dream with me for a moment, perhaps a small 40-bed hospital in Iowa one day in one part of our State, if it was just right, could be an emergency room, an extended-care facility, and perhaps it could be a health resource to that community, with smoking cessation, teaching, different than the role that it plays today with OB, pediatrics, surgery, and so forth.

So I think we're looking at all those things as far as the future. Did I specifically answer your question as far as——

Senator **Pressler**. Yes.

If you wanted to get a little more involved, are you familiar with the all-payer review systems of some of the Eastern States? Would they leave too much of an open door for what would be referred to as abuses or overcharges?

Mr. **Severino**. Well, the advantages of the all payer takes care of the bad debt situation and the cost shifting, and it takes care of, certainly, the research and the universities 'problem for teaching. So, from that standpoint, you know, those things are built in. But when you look at the Maryland system that we've looked at very closely, we don't see any changes in unit costs at all. Costs are still going off the table. It's very cumbersome to administrate; and we feel very strongly, after spending several days out there and looking at that system and talking with the rate review commission people, that they're more impressed with the direction that we're going in Iowa, and are pulling for us to make it work, because it offers more opportunity for less regulation.

Dr. **Levitz**. If I may comment, Senator, as a former academic with the graduate program in hospital and health admission at the University of Iowa, in looking at all-payer systems, you can see that they have successfully held down costs when compared with other systems. Frank raised the issue of how capital was treated and the fact that he believes that capital may be built into an all-payer system, so that once again you have the runaway costs; but in effect, the rate review system can effectively put caps on capital development in the State, such as in Massachusetts at the current time.

Now, whether or not this will have the effect, have the effect of impairing quality, that remains to be seen; but I think the judgment on many of these experiments is still out, and we should be open to the fact that all-payer systems do deal with the major problem that exists today--the problem of cost shifting—in that it does allocate to each payer a fair share of uncompensated bad debt and charity care while at the same time it does have the potential to constrain the growth and to rationalize the growth in a statewide health system, or at least for those hospitals that are covered under rate review. The experiences of Massachusetts, New Jersey, New York, and Maryland I think have indicated that this is the case.

Senator **PRESSLER**. Thank you

We don't want to run up the printing bills, so if you covered the question, skip mine. But I want to thank you all.

Senator **GRASSLEY**. Thank you very much for coming.

I want to thank the panel as well, and we'll go on to the second panel now.

I didn't ask all my questions, but time is fleeting. We'll review them and see what should be submitted in writing.

Thank you all very much.

[Subsequent to the hearing, Senator Grassley submitted questions in writing to Dr. Levitz and Dr. Pfaff. Those questions and their responses follow:]

QUESTION TO DR. GARY S. LEVITZ

One major concern I have is the problem which exists with skilled nursing beds. In many parts of Iowa there is an excess of acute care beds in the same locality where a skilled bed shortage exists. What options do we have to remedy that situation? Do you feel an expanded swing bed program could be effectively implemented without having large acute care hospitals use the expanded program as a way to fill beds which may not be needed?

Response. Although there is a recognized shortage of skilled nursing beds in Iowa, new beds are not being approved through the certificate of need process. Additionally, low levels of reimbursement discourage many from entering this field. As there is a need for skilled nursing care, in those situations where a hospital has beds available, these resources should be used to provide an appropriate level of care at an adequate level of reimbursement.

Large hospitals are experiencing difficulty in placing patients and those hospitals with swing beds are being pressured to accept patient transfers. As a result, some swing bed hospitals have developed protocols outlining procedures for accepting patients and some are attempting to limit transfers to residents of their county, only. Allowing larger hospitals to participate in the program will help to alleviate many of the current problems associated with the unavailability of skilled nursing beds in Iowa.

QUESTION TO DR. ROBERT PFAFF

I have received several inquiries concerning the inappropriateness of having a peer review organization conduct preadmission screening and utilization review out of Des Moines, when the patient, admitting physician, and the hospital are located elsewhere. Could you give your views on the appropriateness of this procedure and its effectiveness?

Response. The Iowa Foundation for Medical Care (IFMC) has long been an advocate of local peer review. That is, we feel that peers can best judge each other's work at the local hospital level. Prior to the enactment of the medicare prospective payment system (PPS), the IFMC delegated its review activity to all but a few hospitals in the State. The question you have posed addresses the changes the IFMC has made in response to new PPS requirements.

In the past, hospitals have employed utilization review coordinators to coordinate the review activity with the medical staff. By law, almost all of the medical review activities cannot be delegated to local hospitals. Hospital review coordinators now must function as employees of the IFMC, and only those hospitals with significant medicare volume can justify a local coordinator. The IFMC does have the latitude to use local hospital physicians as physician advisors in the utilization review process. This means that even though the job of coordinating the review has been transferred to the Foundation, peer physicians at the local hospital are being used to make the vital utilization decisions.

The prospective payment system has created many changes for hospitals and physicians. These changes have caused different kinds of accountabilities. Physicians who must have their patients certified for admission will find any system cumbersome and difficult. The IFMC has attempted to develop review procedures which are fair and equitable and satisfy the requirements of the law.

Senator **Grassley**. We have invited to our second panel people who can speak about the concerns which beneficiaries might have about the medicare situation and about some of the proposals for change. Paul Aardsma is the public relations director for the Iowa Commission on Aging, which carries out the programs made possible under the Older Americans Act here in Iowa. Don Rowen is from Des Moines, and he's executive vice president of the Iowa Federation of Labor. He will give us a view of the federation and its membership on matters before us today. Daryl Siebens is a member of the board of directors of the Iowa Farmer Bureau Federation. He's a farmer himself and is also involved with Blue Cross of Iowa, so he is well qualified to discuss the issues from that point of view as well. Mr. Siebens is from Plymouth County.

I'd ask each of you to come up now, and proceed in the same order in which I introduced you: Paul, then Don, and then Daryl.

Paul, go ahead.

STATEMENT OF PAUL AARDSMA, DES MOINES, IOWA, PUBLIC RELATIONS DIRECTOR, IOWA COMMISSION ON AGING

Mr. **Aardsma**. Thank you, Senator Grassley and Senator Pressler, for this opportunity to come.

Glen Haydon of Mason City, Iowa, prepared this statement to be given at the originally scheduled hearing, but because of other commitments Mr. Haydon is unable to be present today. But he's asked me to present this testimony on his behalf. As you have already mentioned, I am the public relations director for the Iowa Commission on the Aging, and he is employed in the health care delivery system. In fact, he supervises the administration of five rural hospitals in Iowa. So, with your permission, I will read the statement as prepared by Mr. Haydon.

Senator **Grassley**. You'll have to summarize it because we have two panels to hear from in the remaining hour. So do the best you can to hit the highlights.

Mr. **Aardsma**. OK. You have the prepared statement?

Senator **Grassley**. Yes; in fact, I read it on the airplane.

Mr. **Aardsma**. Mr. Haydon points out the fact that the advances that have been made in our medical care system have been a blessing as well as creating some problems for us; and the blessing, of course, is of living longer and enjoying healthier lives, and that individuals are blessed by the fruits of love of family, and the opportunities offered through the American society, and these things should be recognized.

The fact that the social side of our American society has failed to adequately plan for the fruits of the improved health status of the population is unfortunate and brings us to the horns of this double dilemma. We have increasing numbers of elderly living much longer and developing a category of aged elderly which are met by the twin horn—limited financial capacity. We have more seniors, and more seniors with limited capacity to meet the needs of health care.

There is a third horn that Mr. Haydon suggests, and that is that the elderly also consume much more acute services and will continue to do so in the future. One problem he mentions is that medicare cuts are not health care cost-containment actions. This is not playing with words or engaging in a semantic game. There is a major difference between carefully orchestrated programs to contain health care costs matched to alterations in public expectations, of course, and simply cutting expenditures and letting social ramifications shake out where they may.

You've mentioned a number of times the three aspects of this problem: The recipients of care, the providers of care, and the taxpayers; and the administration's efforts to cut back on medicare costs are, of course, on behalf of the taxpayer to hold down the cost and to limit the deficit financing that we have in our Government today.

But one of the problems is that, you know, with the burden that's placed upon the elderly, we are coming to the position where we're going to have a two-tier system—those who can afford quality health care and those who simply will experience a limited amount of care because of an inability to provide it or because of a limitation by the Government in the programs of health care that they provide.

If a person cannot afford the care and if the level of care provided by the Government is not adequate to meet their needs, then that person will simply have to accept their lot in life unaltered by available medical knowledge; and this may be precisely where our country is headed, due to fiscal constraints. The time is now to decide if we're going to move from health as a right, to major limitation, and be very open and clear in explaining this new social value to the citizens of our country. Lofty rhetoric and complicated bureaucratic formulas used to try and cover the realities of the situation will prove a grave injustice to our citizenry. In other words, the Government should be very open and very clear with the American people. If we're going to limit the amount of care that people should have, the people should be notified that there will be this limited care, and we should not have them expecting more than that which the Government is going to provide through this program.

Proposed change in medicare coverage is an enormous gamble. There is an absence of hard evidence that money is actually being saved under the New Jersey system, and it is the opinion of Wilbur Cohen that no thought is being given to the recipients, the elderly particularly. Only the process and mechanics of the bottom line are being addressed at this time in that system.

It's very difficult to try to summarize all that Mr. Haydon has written here, but I think the point is that we need to determine whether we're going to value health care as a right of every individual or whether we're going to look at health care from the limited perspective and provide only that which we can afford to give. With that, I'll close this part and wait for some of your questions.

Senator GRASSLEY. I think your last point was an accurate summation of what Mr. Haydon had to say. He made a very strong case for the fact that we ought to continue to support medicare on its basic and original premise, that it was a right, and that the quality ought to be our first concern.

I want to break in here, because Senator Pressler has to leave and he did want to ask you a question, Paul. So, if you'd allow him to do that before we go on to Don, I'd appreciate it.

Mr. **Aardsma**. All right.

Senator **Pressler**. Yes.

I note that your statement mentions that he supervises five rural hospitals, many of which have a medicare population of 60 to 75 percent. How many beds are most of those hospitals? How big are they, do you know?

Mr. **Aardsma**. I do not know precisely, but it's my understanding that all of these are 50-bed hospitals.

Senator **Pressler**. Around 50 beds. I also notice he waxes eloquent here at the end when he says, "We will have new massive programs called the son of Hill-Burton," which is the old medical assistance program before medicare, "or, in the new society, perhaps the daughter of Hill-Burton, to rectify the error of our ways of the early 1980's." Do you know exactly what he was saying there, or was that——

Senator **Grassley**. I think I can interpret that. He figures that what we're doing now is a really big mistake and one that we're going to be paying for with new programs in the future to make up for what we're doing to rural hospitals.

Isn't that the point?

Mr. **Aardsma**. I believe that is the point that he would make. I should mention that two of his recommendations are, first of all, that there should be the impaneling of a commission, such as the Social Security Revision Commission, a commission that would be able to study this program and come up with some solutions.

The Social Security Commission, of course, came up with recommendations that didn't please anybody, and yet it didn't offend everybody, either. They came up with some very necessary hard decisions, and I think we're going to have to do the same thing with the study of medicare; and perhaps because it is such a political issue, an impaneling of a high-caliber commission could perhaps address these problems and these dilemmas that we face. And the second is the point that there needs to be continued experimentation with alternative forms of health care, the development of health maintenance organizations, and so forth, and the community-based services that would enable an individual to stay out of an acute-care setting.

I believe, from my own perspective, that hospitals have long seen themselves as custodians of acute care and support systems that are necessary to provide that acute care, and perhaps there needs also to be a shifting of the perspective of the health providers so hospitals do not concentrate only upon acute care, but will be concerned with preventive care and long-term care as well as acute care.

Senator **Grassley**. Thank you, sir.

[The prepared statement of Mr. Aardsma follows:]

PREPARED STATEMENT OF PAUL AARDSMA

My name is Paul Aardsma of Des Moines, Iowa. I currently serve as the public relations director with the Iowa Commission on Aging.

I would certainly stipulate that the cost of delivering health care to all critizens of our country has increased dramatically over the past 20 years Developments in health care, through research, new discovery, and new techniques have also had a dramatic impact on longevity in this country, and have produced a very welcome problem. In our rush to criticize we often fail to recognize that living longer and enjoying healthy increased lifespans, blessed by the fruits of love of family, friends, and the opportunities offered through American society, should not [illegible] denegrated. The fact that our citizens have healthier, longer lives is a major accomplishment. The fact that the social side of our American society has failed to adequately plan for the fruits of the improved health status of the population is unfortunate, and brings us to the horns of this double dilemma. Increasing numbers of elderly living much longer and developing a category of the aged elderly are being met by the twin horn—limited financial capacity. The aged elderly may add a third horn to the dilemma for they will consume much more acute services in the future.

Obviously some steps must be taken to match available resources with a set level of care to insure that our elderly citizens find the retirement years all they have come to expect.

Unfortunately, we are actually going through a major social change disguised as health care cost containment. Medicare cuts are not health care cost-containment actions but are acts to cut Federal expenditures. I am not playing with words or engaging in a semantic game. There is a major difference between carefully orchestrated programs to contain health care costs, matched to alterations in public expectations of care, and simply cutting Federal expenditures to a predetermined dollar number and letting the social ramifications shake out where they may.

It is time for us to be very honest with the population of this country, particularly the elderly citizens. If we as a society, and our Government, intend to say that health as a social value has been replaced by health as a commodity, we had best make that announcement in clear uncertain terms. Unquestionably, the legislative proposals to reduce spending for the health care of our elderly are moving us from a society of rights, to a society of limits. I would suggest to you that this raises many ethical and social issues which we have chosen to avoid up to this point. I certainly do not wish to appear to be waving negative flags but the potential for a two-tiered health care system is very real.

Those that can afford to pay will receive the very best care available and those who cannot pay, but must rely on Federal programs, will receive care to a certain level. Beyond that level, the person will simply have to accept their lot in life, unaltered by available medical knowledge. That may be precisely where our country is headed due to fiscal constraints. If it is, it is certainly a major change in expectations for millions of our senior citizens and those of us who will be senior citizens in the future. The time is now to decide if we are going to move from health as a right, to major limitation, and be very open and clear in explaining this new social value to the citizens of our country. Lofty rhetoric and complicated bureaucratic formulas to try and cover the reality of the situation will prove a grave injustice to our citizenry.

Proposed changes in medicare coverage are an enormous gamble. Last week I had an opportunity to visit with Wilbur Cohen, former Secretary of HEW. In his opinion the DRG program was adopted with incredible speed, absent any hard evidence from the New Jersey system that money is actually being saved. Mr. Cohen noted that in his opinion little or no thought is being given to the recipients, the elderly. Only the process, the mechanics, and the bottom line are being addressed at this time. We are doing little to build up the competence of Federal or State agencies to care for people under this new style of health care delivery. The health impact, the social impact, and the lifestyle impact on the elderly, has fallen by the wayside in our zeal to approach this very human service, with a bottom line mentality.

I would concur absolutely that we should make every effort possible to look for ways to contain costs in the delivery of health care. Such efforts must be combined actions, looking at cost containment from multiple action points—hospital and doctor services, improved operational efficiencies, and dollar savings within the Government bureaucracy, carefully prescribed limits on services for certain recipients when herculian care is more for family members than for the patient themselves, and some additional involvement of the general fund; dollars contributed by all Americans.

Americans value their health, perhaps more than any other citizens in the world. They have a special appreciation for good health and the benefits it can bring, particularly as they age. The programs proposed by the Congress would limit time in the hospital to a cookbook formula requiring the elderly patient to progress through the acute episode on a rapid schedule.

The expiration of that dollar amount, the DRG, will be the signal for the transfer of that patient to a lesser skilled level of care than that found in the hospital. Where will he or she go? What preparations have we made as a society, for this dramatic change in care other than promptly passing some legislation? For years our health planning formulas have impeded the growth of nursing homes, urging the development of other forms of care. It hasn't happened to any degree.

In a study conducted by the Iowa Department of Social Services, leading citizens were asked to identify their problem perceptions in care of the elderly in this State. Eighty-seven percent of the respondents noted that there was a problem in keeping the elderly and disabled in their own homes; 84 percent indicated a problem in isolation and loneliness for the elderly; 75 percent of the respondents indicated a problem with inadequate home health care for the elderly; 62 percent of the respondents indicated that there were problems with mistreatment of the elderly; 61 percent of the respondents indicated a lack of transportation for the elderly; 55 percent of the respondents indicated problems with a lack of comprehensive services in rural areas; and 52 percent indicated problems with inadequate housing for the elderly.

Yet, with those problem perceptions unresolved, new health care legislation has proceeded to move the elderly out of the acute-care setting with all deliberate speed, undoubtedly expecting that somehow, magically, other elements of society would step in and care for that elderly person during the remainder of the recovery period. In Iowa, we have a definite shortage of skilled nursing beds, we have a definite shortage of full service home health care programs, and we have that laundry list of perceived problems just read to you. Those are the very concerns that elderly will now be forced to face in larger numbers and in states of depleted health.

One out of 10 Iowa families is headed by a lone female. This number has risen by 55 percent in the last 10 years with one-third of them having income below the proverty line. Yet Congress has seen fit to severely restrict the development of elderly congregate housing—where the widowed elderly person could go for companionship, care, and sustenance during a recovery or rehabilitative period.

The report of the U.S. Senate Special Committee on Aging, dated March 4, 1983, noted in part, "Because of rising costs there has been no serious consideration of any legislative proposal to address the gaps in medicare coverage which still remain, such as lack of coverage for long-term care, preventive services, outpatient drugs, basic dental services, and eyeglasses."

More dollars? Perhaps, but those are the very kinds of services that will allow the elderly to stay out of the acute-care setting and still receive health care designed to maintain a fuller more active life.

In talking with hospital social workers, I find that the pinch of inflation on fixed incomes is already having its toll on elderly health care. Numerous individuals have been giving up their Blue Cross/Blue Shield coverage because of increased costs of premiums. The result is increased expenses for them to cover whenever they are hospitalized. In the words of one social worker, the elderly in this country have grown up in a time of conscientious paying of debts. Therefore, they feel very strongly about paying the hospital bill and are now sacraficing the necessities—giving up meals and medications to pay their hospital and doctor bills. This then increases the probability of a return episode of the illness or other complications; more hospital and doctor bills, more pharmaceutical bills, and the circle starts all over again, and again, and again.

Already our social workers are beginning to find elderly patients are staying away from the doctor and staying away from possible hospitalization out of fear of using the last of their nest egg when they are transferred from the acute-care setting to the nursing home for the rest of their recovery. We can certainly expect this phenomena to increase dramatically as the DRG system takes over and hospitals move with all deliberate speed to see that patients are discharged prior to the expiration of the DRG payment rate.

Once again, our Government continues to look at only one piece of the system and attacks only one piece of a very human problem as if it were a production line item in a manufacturing plant budget. It is incredible to believe that somewhere in Washington people fear that we can simply slow down the assembly line and reduce production to decrease inventories, thus positively impacting the bottom line.

Frankly, I am weary of hearing people talk about the percent of gross national product devoted to the care of our elderly or the delivery of health services to our elderly. If the people of our country are not the most important commodity that we have, then our country is in a much faster social decline than I may have imagined.

I would urge you to impanel a commission of the highest caliber representing all of the disciplines that have insight and understanding of not only finance, not only medical and hospital operations, but social and cultural insights, people who can guide and direct this very thorny issue with due attention to values as well as budgets.

When someone wants to build an industrial plant or shopping center in this country, they are required to provide an environmental impact statement. This environmental impact statement must address all sorts of issues before the first spade of earth can be turned. Where is the environmental impact statement on changes in the medicare program to serve the elderly citizens of this country?

Changes must be made. Unquestionably, we do not have unlimited resources to deliver health care and other social services to the citizens of this country whatever their age. The time for playing games with our senior citizens is long past. If we are going to change the social fabric of this country, then let that be a decision that is made with the full knowledge of everyone.

Let's put away forever piecemealing, tinkering with the mechanics of programs our seniors have come to depend upon. I am convinced that a multidisciplinary approach can be found in which all generations contribute a bit more, health care modifies its services to the seniors in a way which does not force them into a second-class patient status, and the Federal Government itself becomes a far more efficient and less costly administrative machine. Continued experimentation with HMO's for the elderly and other preferred provider contractual arrangements should be encouraged with all deliberate speed.

The fallout from the current mechanical changes in medicare is only just beginning. I supervise the administration of five rural hospitals, many of whom have medicare populations of 60 to 75 percent. Aged elderly with problems in transportation, loneliness, single spouse households, and facing the lack of comprehensive services in rural areas will soon face the possible loss of the rural hospital they have come to depend upon due to the inability of such facilities to continue to exist where the bulk of their service is to the elderly.

As sure as I am sitting here, the big wheel will turn and in the years ahead, our country will recognize the folly of planning health and social services through budget cuts rather than in a rational service delivery pattern manner, and we will have new massive programs called the son of Hill-Burton, or in the new society, perhaps the daughter of Hill-Burton, to rectify the error of our ways in the early 1980's.

That is, of course, unless we are smart enough in the early 1980's to recognize the need for a modification of the social and cultural expectations of our people along with the modifications of services available. You can't have one without the other and expect to create a lasting program that is acceptable to the citizens of this country and future generations.

Senator GRASSLEY. Thank you. Don, would you proceed now with your testimony, please?

STATEMENT OF DONALD R. ROWEN, DES MOINES, IOWA, EXECUTIVE VICE PRESIDENT, IOWA FEDERATION OF LABOR, AFL-CIO

Mr. ROWEN. Thank you, Senator Grassley. Thank you, Senator Pressler.

Senator Grassley, I don't—I can go through, you know, take the time to go through it; and you have it in your hands, and I don't know that there's a lot of value in me just highlighting it for the audience. Your questions have been very good, and it won't hurt my feelings if we just move along.

Senator GRASSLEY. I would appreciate it if you do highlight a little bit.

Mr. ROWEN. In chatting about it, we've had earlier discussion on the proposal for the deductible. I'd just like to say that the proposal would only cover catastrophic-related expenses incurred in the hospital and do nothing for high medical expenses incurred outside the hospital. Only 177,000 of the 29 million medicare beneficiaries ever stay in the hospital long enough to benefit from the proposed change. Since the average length of the hospital stay for persons over 65 is 11 days, this proposal would require senior citizens to pay $650 out of pocket per hospital stay, which would amount to $300 more than is required under current law and would represent almost 2 months of benefits for the average widow on social security.

One of the other issues discussed here as a means of reducing medicare expenditures was a proposal to give medicare beneficiaries a voucher equivalent to the cash value of medicare and encourage them to shop around for an insurance policy which meets their needs. We strongly oppose the voucher proposal. We believe the vouchers would lead to the dismantling of the medicare program, reduced access to health care, and higher program costs.

Vouchers will not work, because the medical care system does not respond to the traditional laws of supply and demand. Consumers cannot predict what health care needs they will have in the future. As a result, financial incentives could be used to influence the healthiest beneficiaries to abandon medicare for less health insurance coverage. Since even the insurance industry has acknowledged that private insurance cannot duplicate medicare coverage, senior citizens choosing low option plans would be left unprotected against the high cost of getting sick. As for the Federal Government, its costs would rise because of the additional expense associated with treating the most difficult and expensive cases without the availability to offset higher costs by having beneficiaries in a program who are healthier and less expensive to treat.

Also, if, as predicted, large numbers of beneficiaries opt out of the medicare program for less expensive private insurance, medicare will lose any leverage it now has to reduce the rates of increase in hospital costs or monitor the quality of care.

And we have five recommendations. We believe that we should take steps to reduce the annual rate of increase of physician fees by eliminating the current method of reimbursing doctors on the basis of reasonable and customary charges and setting prospective rates which are negotiated in advance for physician fees. medicare cost containment cannot be confined to hospitals. It must include physicians, who play such a pivotal role in the medical care decisionmaking process.

Another alternative would be freezing physician fees and mandating assignment, repealing immediately the return on equity allowance under the current law for proprietary hospitals, or imposing a temporary freeze on new hospital construction, and repealing the adjustment of the DRG system granted to teaching hospitals based on a ratio of house staff to a number of days. Rather than simply doubling the current adjustment, Congress should develop a plan for supporting hospital-based teaching programs without burdening the medicare program. That's sort of a synopsis of what we've said here

Senator GRASSLEY. Thank you, Don.

PREPARED STATEMENT OF DONALD R. ROWEN

The Iowa Federation of Labor, AFL-CIO, is pleased to have the opportunity to share its views with you on proposals to reduce funding for medicare.

We hope you will look long and hard at the effect which recent budget cuts have had on the ability of the medicare program to cushion the blow of economic devastation resulting from the recession and look elsewhere for ways of raising Federal revenue. For the strength of our country is the sum total of the health and welfare of its people. Further cuts in medicare will only prolong the suffering that is going on throughout the country and hinder any hope of an economic recovery that will benefit every group in our society.

On January 1, 1984, the deductible for hospital insurance (part A of medicare) will rise from $304 to $350. The premium for medical insurance (part B of medical) will rise from $12.20 per month to $13.50. Earlier this yer the administration released its proposals to cut the medicare program by $1.3 billion in fiscal year 1984. If enacted, the new cuts would require medidcare beneficiaries, who now pay a deductible for the first day of care and nothing for the second through the 60th day, to continue to pay the deducible and an additional 8 percent of the deductible per day for the second to the 15th day and 5 percent of the deductible for the 16th through the 60th day. After the 60th day, medicare would waive all costs.

The administration attempted to market this proposal by stressing the additional coverage for catastrophic-related expenses. However, the proposal would only cover catastrophic-related expenses incurred in the hospital, and do nothing for high medical expenses incurred outside of the hospital. Only 177,000 of the 29 million medicare beneficiaries ever stay in the hospital long enough to benefit from the proposed change. Since the average length of a hospital stay for persons over 65 is 11 days, this proposal would require senior citizens to pay $650 out of pocket per hospital stay, which would amount to $300 more than is required under current law and would represent almost 3 months of benefits for the average widow on social security.

Another proposal advanced by the administration was to raise monthly premiums paid by beneficiaries for medical services (part B) from the current level of $12.20, which represents 25 percent of program costs, to 35 percent in 1988. If Congress adopted this proposal and medical costs continued to rise at current rates, the monthly premium would rise to $31.60, or almost three times the amount medicare beneficiaries now pay. Such a dramatic increase in premiums would force large numbers of beneficiaries to drop part B and go without physician and laboratory services.

A third proposal suggested by the administration was a freeze on physician reimbursement. Since Congress has not yet required physicians to accept assignment, i.e. to accept as full payment the fees medicare determines are fair, as the Iowa Federation of Labor has long urged, this provision would only result in fewer physicians accepting assignment and their turning to patients to make up any reductions in reimbursement.

After looking at the effect of the administration's budget proposal on medicare beneficiaries, the Senate rejected one-half of the administration's proposed reductions. The Senate Budget Committee discarded the idea of imposing additional copayments on part A services, but did recommend that the committee consider raising part B premiums for individuals and families with adjusted gross incomes of $25,000 and $32,000, respectively.

In the opinion of organized labor, the savings that would be associated with implementation of this proposal are totally outweighted by its long-run negative impact on the medicare program and its beneficiaries. If enacted, this proposal would significantly alter the fundamental premise of the medicare program that access to medical care is totally independent of one's ability to pay and, depending upon where income levels are set, could be a significant barrier to care now or in the future for many senior citizens.

The other issue that has been discussed, as a means of reducing medicare expenditures, is the proposal to give medicare beneficiaries a voucher equivalent to the cash value of medicare and encourage them to shop around for the insurance policy which meets their needs. Organized labor strongly opposes the voucher proposal. We believe vouchers would lead to the dismantling of the medicare program, reduced access to health care and higher program costs.

Vouchers will not work, because the medical care system does not respond to the traditional laws of supply and demand. Consumers cannot predict what health care needs they will have in the future. As a result, financial incentives could be used to influence the healthiest beneficiaries to abandon medicare for less health insurance coverage. Since even the insurance industry has acknowledged that private insurance cannot duplicate medicare coverage, senior citizens choosing low option plans would be left unprotected against the high cost of getting sick. As for the Federal Government, its costs would rise because of the additional expense associated with treating the most difficult and expensive cases without the ability to offset higher costs by having beneficiaries in the program who are healthier and less expensive to treat.

Also, if, as is predicted, large numbers of beneficiaries opt out of the medicare program for less expensive private insurance, medicare will lose any leverage it now has to reduce rates of increase in hospital costs or monitor the quality of care.

If you wish to reduce Federal expenditures for medicare by $400 million in fiscal year 1984 as called for in the budget agreed to by the conferees, the Iowa Federation of Labor suggests the following:

(1) Taking steps to reduce the annual rate of increase in physician fees by eliminating the current method of reimbursing doctors on the basis of "reasonable and customary charges" and setting prospective rates which are negotiated in advance for physician fees. Medicare cost containment cannot be confined to hospitals. It must include physicians, who play such a pivotal role in the medical care decision-making process.

(2) Another alternative would be freezing physician fees and mandating assignment. If physician fees were to be frozen without requiring physicians to accept assignment, charges that would normally have been reimbursed by medicare would be passed on to patients.

(3) Repealing immediately the return on equity allowance under current law for proprietary hospitals. Even though Congress has decided to phase out return on equity after fiscal year 1986, the need to reduce medicare expenditures is so pressing, this decision bears reexamination.

(4) Imposing a temporary freeze on new hospital construction. Until Congress determines how capital should be incorporated into hospital reimbursement rates, a freeze would put the brakes on the dramatic rate of growth in uncontrolled capital expenses, which, inevitably result in higher operating expenses.

(5) Repealing the excessive adjustment under the DRG system granted to teaching hospitals, based on the ratio of house staff to the number of beds. Rather than simply doubling the current adjustment, Congress should develop a plan for supporting hospital-based teaching programs without burdening the medicare program.

Taken together, the previous suggestions could save the medicare program billions of dollars annually, far more than the $400 million spending reduction target for fiscal year 1984, and avoid any need to cut benefits or impose higher beneficiary cost sharing.

Senator **GRASSLEY**. Daryl.

STATEMENT OF DARYL SIEBENS, AKRON, IOWA, MEMBER, BOARD OF DIRECTORS, IOWA FARM BUREAU FEDERATION

Mr. **SIEBENS**. I'm Daryl Siebens, a farmer in Plymouth County. I presently serve as a member of the Iowa Farm Bureau Board and also serve on the board of directors of Blue Cross of western Iowa and South Dakota. I'm making this statement on behalf of the Iowa Farm Bureau Federation; and there I'll think I'll throw that aside and try to give you a couple examples of what we're talking about.

We're very concerned, from the taxpayer point of view; and, of course, I have no professional knowledge of the medicare system and the hospital delivery system, but I would suggest to you that I do represent a group of professional taxpayers. On that basis, we feel we are overburdened and greatly burdened with social security taxes already, put together with—and I can think of a couple examples that are not in here, not in the testimony; but I'm thinking of a person who has $100,000 invested in stocks and has a job in some manner that nets him $10,000 a year. I'm thinking about a farmer, then, who has $100,000 invested in a sole—proprietor business, with a capital-intensive thing like farming is. We're talking about farmers, a farmer with $100,000 invested in his business, and hopefully out of that business he can net $20,000 a year.

The one who has $100,000 in stocks and the $10,000-a-year job hopefully could have a combined income of $20,000 a year. The employed person has $700 deducted from his $10,000 wages. His employer puts in $700. The total on that end of the social security system is $1,400. The farmer with the same income, only having had little investment in the business, pays social security taxes in 1984 of $2,260. Same income, same everything happening. There's no provision in the Tax Code for a return to capital prior to the calculation of the self-employment tax; and so, you know, this thing gets out of balance really rapidly.

There is a precedent for this, and it would seem to me that this is the one thing that you ought to consider, even on the Finance Committee. If you recall, several years ago, when we had two duplicate tax rates, there was one tax rate maximum for earned income and one for unearned income. If I understand correctly, the IRS arbitrarily came into some farm tax returns and said, "You can't make all that money from your labor. Some of that certainly was return of capital," and on that basis they increased those tax liabilities on the basis of return to capital. I think we ought to go to the same premise that happened then, that a good portion of farming income is a return of capital. We at the moment pay social security tax on that.

One other example I'll give you quickly is, for instance, if I, operating as a sole proprietor, have a $40,000 savings account and I don't have a tractor—I rent my tractor for the return on that, which let's say is $4,000 a year—if I rent a tractor, the net return on my farming operation is reduced by $4,000, so that I pay in rental or lease for the tractor The income I get from the savings account is not taxed as earned income. So I decide some grand and glorious day I'm going to take the $40,000 and go buy a tractor. Now, my farm nets me more, and I have the privilege of paying additional social security or self-employment tax on the $4,000 more the farm makes, see. So it doesn't appear to me that that's stimulating a very good business proposition.

Enough of those. I'm sure you have a tremendous dilemma. There are more people over in that medicare age, and health costs increases are certainly something everyone is faced with. We would suspicion that the prospective payment ought to be helpful in containing costs to some extent. Coinsurance I think will help, if we have those who benefit taking a little bit of the share of the load. That certainly could help. Maybe our expectations are too high on what should be available. I read a recent study that said the quality of life was not necessarily dependent on the amount of health care that was afforded.

In conclusion, then, I'd say that the resolution will require sacrifice on all people, so we'd like you to take a look and make sure that you try to deal with everyone on a fair and equitable basis.

[The prepared statement of Mr. Siebens follows:]

PREPARED STATEMENT OF DARYL SIEBENS

My name is Daryl Siebens. I am a farmer in Plymouth County, Iowa. I presently serve as a member of the Iowa Farm Bureau Federation board of directors and am a member of the board of directors of Blue Cross of Western Iowa and South Dakota. I make this statement in behalf of the Iowa Farm Bureau Federation.

The crisis that is predicted in the medicare trust fund is of special significance to farmers. Social security taxes are the source of revenue for the medicare trust fund. While Congress passed extensive amendments to the Social Security Act in 1983, little attention was paid to the medicare hosptial insurance portion of the social security payment other than to note that the medicare trust fund was in trouble just as were the old-age, survivor, and disability insurance funds.

Social security taxes are a burden for farmers and will be increasingly so due to the unique nature of farming. Beginning in 1984, farmers will pay double the amount withheld from wage earners making a comparable income. A farmer paying the maximum amount of social security in 1984 will pay 27 percent more, or a $900 increase, over that paid in 1983. Even those not paying the maximum will find their social security payments rise by 21 percent on the same income. The reason for the increases, of course, is because beginning in 1984, farmers will pay both the employer and the employee taxes on their own income.

We believe also that there is an inequity in the way social security taxes are assessed against farm income. Substantial portions of the income for farmers are related to a return on their investment in business property, income that is not normally subject to social security taxes. In addition, farm income is not lowered by investment credit when social security taxes are calculated. And, personal exemptions and investments in Keogh plans are not deductible for social security purposes. As a result, many farmers pay more social security tax than they do Federal income tax.

The crisis in the medicare trust fund, in some respects, parallels the crisis in the old-age, survivor, and disability insurance funds that were dealt with earlier in 1983. In both cases, there is an attempt to pay out more from a fund than the income will support. We hope Congress does not choose the same course in meeting the medicare crisis that it did in meeting the other social security fund problems earlier this year. For a number of years, Congress added benefits without regard to the income level of the old-age, survivor, and disability insurance funds. Rather than pare some of these benefits back to cure the funding imbalance, Congress chose the route of mainly increasing taxes. We hope that does not occur in dealing with the medicare trust fund.

Unlike the crisis in the old-age, survivor, and disability funds, the crisis in medicare comes more from rapidly increasing medical costs rather than from expanded benefits. The problem with the medicare trust fund may not be completely solved, and may not be solved at all, unless we can control the growth of health care costs in this country. With over 10 percent of our gross national product going to health care, and with this proportion of consumer spending rising rapidly, cost containment of health care is a priority not only for solving the medicare problem but for making health care available to all citizens. We cannot go on with health care costs rising at three times the rate of inflation.

Just as we have learned to live full lives with less energy, we must learn also to live our lives with less medical service from professionals. We can probably do it with no increase in mortality rates or placing public health in jeopardy if we approach health care as a national problem as we did the energy crisis. We have probably been obsessively concerned with quality health care but have not yet really tried to avoid extravagance and waste in health care. We simply must cut the cost of health care or the economic burden will make it unavailable to many of our citizens.

The newly enacted prospective payment plan for medicare expenses is encouraging. It is one of the few programs that we have tried that will provide an incentive for cost control. We hope hospitals and other health care providers will accept this method of payment as a challenge to bring about efficiences in their operations rather than consider this method as an impediment to progress or an incumberance that forces them to charge other patients more. We hope the built-in incentives for efficiency will mean lower medical costs for other than medicare payments rather than greater costs.

The expanded use of hospital coninsurance probably has the best chance for making significant savings to the medicare trust fund. Coinsurance also has the advantage in that the recipient of the health care treatment will be more cost conscious and will be a better shopper for less costly health care. Although some medicare recipients will find increased coinsurance to be very burdensome, many others will not. Medicaid assistance is also available to help those over 65 in need of welfare.

A resolution to this crisis will require sacrifice on the part of many segments of the population. We are hopeful that Congress acts responsibly in fashioning a long-term solution, balancing the interests of all citizens.

Thank you for your consideration of our views.

Senator GRASSLEY. Mr. Siebens, the emphasis in your statement is primarily on the expenditure side.

Mr. SIEBENS. Yes.

Senator GRASSLEY. As opposed to the tax side.

Mr. SIEBENS. When you look at the dilemma that farm people are in now, not necessarily farm people but any sole proprietor capital-intensive business, persons are paying an inordinate amount into the social security system already. If you raise everyone's taxes on the same basis and let that inequity keep going, then I don't know where we are going to go.

Do you recall when you were in the Iowa Legislature, we had a little problem with tax—property tax? And I have had years in the past where I, operating as a sole proprietor, found that the social security I paid would have outstripped the property tax on a per acre basis. So at that particular point, I guess it gets to be pretty critical.

Senator GRASSLEY. At your recent convention 2 weeks ago, did your voting delegates deal with medicare problems at all?

Mr. SIEBENS. I don't think we have specifically, other than the fact that when things grow out of proportion, we've got to find some ways to help people help themselves, or at least—I really enjoy the glorious system that we have for health care service best. But if we just plain can't afford it anymore, then something has to change.

Senator GRASSLEY. Paul, I've referred two or three times in my questioning to the prospective payment system that we just started to phase in, and I want to know whether or not you and your organization in the various Iowa regions and counties have had any experience or concern that the new system is going to adversely affect the quality of care afforded the elderly. Second, do you have any evidence yet that the elderly people who are covered by medicare understand that the new prospective reimbursement system is now in effect or in the process of being phased in?

Mr. AARDSMA. Well, to answer your last question first, I do not feel, from my knowledge, that the senior citizens, as a whole, are aware of what is happening. They are only aware that a greater portion of the costs of medical care are falling upon them, and many of them are withholding or keeping—hesitate to seek medical care, because they have the feeling that they cannot afford it. The first part of your question—will the prospective payment system affect the quality of care—I don't believe we have any hard facts that we can really make a judgment at this point.

I personally fear that the prospective payment system may result in some shifting of medical costs, and this, I think, would be detrimental to the whole system.

Senator GRASSLEY. Don, you were very specific in your statement and summary about the five ways you think we should deal with the medicare problem. Do you see any tension between your suggestions and the long-term commitment toward providing quality health care?

I particularly ask you to comment in view of a $300-billion deficit that we're facing by the mid-1990's. Am I to surmise from your statement that you would not be supportive of any increased costs to beneficiaries and would rely instead on cutbacks in payments to providers and/or increased Federal revenue?

Mr. ROWEN. That's almost right. There is certainly a discussion point in the statement here about what we're discussing, whether it's—it is a cutback to providers. There's that whole exercise of whether that's real, ought not be done, and those kinds of things. Other than that, your statement is fine. Just to go through that a little bit—remember the last time we met? I chatted with you. We chatted about the major industrial plant in this State.

Senator GRASSLEY. You are referring to the board which is trying to deal with health care cost increases?

Mr. ROWEN. Same board that Frank works for.

Senator GRASSLEY. Yes.

Mr. ROWEN. I would go through it again, without the names.

That major industrial plant in a major city in Iowa cut their hospitalization in half, and they still pay the same amount of dollars for that; and a leading insurance person said, "No, Don, you have the facts wrong. They increased benefits and those kinds of things." I went back to that company executive and said, "I told Senator Grassley that you cut utilization in that major city by 50 percent and it cost you the same dollars."

He said, "Don, you go back to Senator Grassley and tell him that's absolutely right." When we get through, I think I'll give you that staff person's name, because I think they've got a lot of information, talking about the kinds of things that Frank talked about here.

You didn't see some of this here, because I don't feel very comfortable saying some of the things we do in Iowa we might want to pass through into law across the Nation. We're working through some of these things. That's why you didn't see some of that there. But those are the kinds of things we need to do; and I think Frank does a better job explaining that than I do, but those are the kind of things I think we need to keep continuing and doing more and more of here in Iowa.

Senator GRASSLEY. I think I know what company you're talking about, but let us just leave it in the abstract. There's a lot of misinformation out on that particular——

Mr. ROWEN. No, there isn't misinformation. Some of the misinformation comes about——

Senator GRASSLEY [interrupting]. Misinterpretation, then.

Mr. ROWEN [continuing]. From an insurance executive that perceives something else as going on out there out in the world. The data commission, as Frank had talked about, should tell us more facts there, also.

Senator GRASSLEY. OK.

Paul, back to you again. I am seeking some leadership from your organization as we try to deal with this medicare program. We have been talking all day about medicare facing severe financial difficulties. The ultimate goal in changing medicare is to guarantee the long-term viability and solvency of the program. I think we all agree on that. In view of the magnitude of the deficit medicare is facing or will be facing, do you feel that it is inappropriate to consider benefit restructuring options? I say that as much to you, Paul, as in reference to Glen's statement. I think Glen would be very negative in responding. But I would ask you in your work, which is more on a day-to-day basis with the Aging Commission, if you feel the same way yourself?

Mr. Aardsma. Would you state that first part of your question again?

Senator Grassley. The question is whether or not, considering the big job we have ahead of us with medicare, do you feel that it's inappropriate to consider benefit restructuring options, with at least equal emphasis on revenue or maybe even greater than equal weight, upon restructuring?

Mr. Aardsma. Well, I think restructuring of the benefit program has to be considered as one of the options. It's certainly not something that we would like to see happen in terms of limiting the amount of care that's going to be provided, especially to the senior citizens, but I don't think we have any alternatives. We go back to the basic statement that Mr. Haydon made, that we have to decide whether we're going to consider health care as a right or whether we're going to consider health care as a limited blessing that will be provided for those who can afford it.

I think we need to recognize that we never have had the care provided on a needs basis, that is, financial need basis. Medicare is provided to all on an age criteria only, and perhaps we need to look at medicare not as a primary provider of a payment for health care but as perhaps a secondary or tertiary provider of health care.

Senator Grassley. I have no other questions that I'm going to ask at this point. I did have several other questions, and will probably submit some of them to you in writing.

I thank you very much for your participation in this panel. Thank you.

[Subsequent to the hearing, Senator Grassley submitted questions in writing to Mr. Aardsma. Those questions and Mr. Aardsma's responses follow:]

Questions to Paul W. Aardsma

Question 1. Much has been written of late explaining that when medicare was first passed, the beneficiaries were to pay 50 percent of the part B cost. The administration has previously proposed an increase in the part B premium from its current 25 to 35 percent. Given the historical background concerning Congressional intent, why do we see so much opposition to this plan?

Answer. Opposition to increases in the beneficiary share of part B costs is due primarily to the fact that those who depend most on medicare coverage are the low-income elderly who can neither afford supplemental health insurance to cover those costs unmet by medicare part B, nor can they afford to absorb such proposed increases due to the fixed nature of their income.

Question 2. A recently released survey conducted by Louis Harris & Associates dealt specifically with the issue of health care cost containment in both the public and private sectors. One of the findings of that survey is that the American people are willing to accept a broad range of policies which involve some sacrifices. Included in the list of policies most people are willing to go along with are increased deductibles and repayments, prepaid plans such as HMO's preferred provider organizations (PPO's), policies which encourage treatment outside the hospital, and greater use of nurse-practitioners and physicians' assistants. What type of support do you feel your organization could lend to such options?

Answer. I personally would encourage use of outpatient services, prepaid plans such as HMO's, and I would also encourage greater use of paraprofessionals if some controls are placed upon filing of malpractice suits. This would protect medical care personnel in the provision of good faith and practice services. Control of malpractice suits should lead to lowering of malpractice insurance rates which in turn should be reflected in lower medical care costs. Other cost-sharing techniques should be based upon ability to pay.

Question 3. If cost-sharing proposals were to be considered by Congress, do you advocate one type over another? That is, do you see one kind of cost sharing option such as coinsurance, copayments, premiums or deductibles, as being less onerous than others?

Answer. Cost-sharing proposals potentially lead to a two-tiered system of health care. What is needed most is a mechanism to control spiralling hospital and physician charges. In my opinion, demand for services is not patient demand but doctor demand—with patients being billed for the service. Incentives are needed to reduce care costs. I believe health care should be the right of all with costs of care assumed by patients on an "ability to pay" basis.

Senator GRASSLEY. Our final panel, is going to be short one witness, because Dr. John Rhodes of the Iowa Medical Society is unable to be here because of the weather. We are going to include, though, his testimony on behalf of the society as part of the official record.[1]

I want next to invite two witnesses to the table: Harold Linden and Sister Mary Elizabeth Burns. Both are of Sioux City. Harold is vice president and director of the Government programs for Blue Cross of western Iowa and South Dakota. Blue Cross has an important role in the medicare system, both as a financial intermediary and as an insurer for health care. Sister Mary Elizabeth Burns, also of Sioux City, is the administrator of the Marian Center, and she will discuss some of the concerns that the Iowa Hospital Association has with regard to the medicare situation.

I would like to publicly thank Sister Mary Elizabeth for the time she showed me around her new facility and for inviting me to the dedication ceremonies, and also for your continued close communication with my office.

Harold, I will have you start off since I introduced you first.

STATEMENT OF HAROLD W. LINDEN, SIOUX CITY, IOWA, VICE PRESIDENT OF GOVERNMENT PROGRAMS, BLUE CROSS OF WESTERN IOWA AND SOUTH DAKOTA

Mr. LINDEN. Thank you Senator Grassley

We appreciate the opportunity to present our views and discuss the crisis in medicare proposals for reform from our perspective. We share your concern about rising health care costs and the prospect that unless action is taken, the medicare program will face severe financial problems.

There are several options to solve our medicare financing problems. However, the choice will be difficult. One method would be by raising taxes. Reducing benefits or reducing eligibility are two other methods. Still another method would be by containing costs for covered services. Increasing deductibles on copayments would reduce medicare spending, however, we question if all beneficiaries are in a position to absorb these annual increases. That burden results in either increased out-of-pocket expenditures or increased premiums from private supplementary health insurance. The beneficiaries who will not be able to afford increased premiums are the ones least able to afford the increased deductibles and copayments. This also affects the providers by increased bad debts.

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[1] See appendix.

It is important that there is an adequate utilization review program in place to review the need for services furnished to medicare beneficiaries in skilled nursing facilities and in the exempt units of the hospitals. We would recommend that the professional review organization be responsible for this function along with the other responsibilities they will assume under the new prospective payment system program. Proper utilization of outpatient services is a means of reducing costs, and it is important that adequate review will be made for these services.

The successful implementation of any payment proposal rests on technical details and the skills of the intermediaries. We believe that the present system and negotiated budgets for contractors is serving the program well. Administrative costs per claim have shown a steady increase over the years, while the program's savings achieved through audit and medical review activities have increased. Benefits paid by our plan in 1972 were $43,804,000, and in 1982 they had increased to $184,431,000, for an increase of 421 percent in 10 years. Our administrative costs for 1972 were 1.5 percent of the benefits paid, and our administrative costs for 1982 were 0.7 percent, a significant reduction. It is apparent that the crisis is in the benefits-paid area.

In conclusion, we are working closely with the providers and the regional office to implement the PPS program, prospective payment. It is our opinion that it will take time to evaluate this program to determine its effectiveness. Questions still exist on how it will affect medicare expenditures, beneficiary access, quality, and community resource allocation.

Thank you.

Senator GRASSLEY. Thank you. Sister Mary Elizabeth.

STATEMENT OF SISTER ELIZABETH MARY BURNS, PRESIDENT, MARIAN HEALTH CENTER, SIOUX CITY, IOWA

Sister BURNS. Thank you. My name is Sister Elizabeth Mary Burns. I am president of Marian Health Center.

Senator GRASSLEY. I am sorry. I called you Sister Mary Elizabeth.

Sister BURNS. It's Elizabeth Mary, but that's all right. I guess most people are Mary Elizabeth or Mary something.

Senator GRASSLEY. I am sorry I didn't remember very well from our previous meeting.

Thank you for correcting me.

Sister BURNS. Thank you.

I am a member of the Iowa Hospital Association's Committee on Governing Boards, and I represent today that organization, which is comprised of hospitals which are owned and operated throughout the State by city, county, and State government, church groups, and nonprofit corporations under the laws of this State. There is only one investor-owned hospital in the State at this time, so all of the rest of them are really basically not-for-profit hospitals.

I really want to thank you for giving us the time this afternoon to present to you some of the concerns which we have about the service that we can render to the medicare recipients under the new programs of prospective payment. Iowa's population consists proportionately of more people over the age of 65 than most States in the United States. Latest figures indicate that we rank fourth highest in the Nation when the number of over-65 people is compared to the total population of the State; and of course that has some tremendous demographic implications, because in some Iowa hospitals our medicare patients exceed 60 percent of the total patient days of the services rendered. With high utilization of hospital services by medicare patients, then it is important to note that any changes in the program regarding whether these people are eligible for Medicare benefits, how much is covered, and how it's paid for has a multitude of implications for the health care provider. It would not be an understatement that the destiny of many of our hospitals in rural Iowa is directly linked to the direction which the medicare program will take in the near future.

Health care providers, primarily hospitals, have noted in recent years that both Federal and State governments rather arbitrarily reduce payments for the services which have been given whenever it is necessary to constrain government expenditures; so anytime you have an entitlement program, the people who are responsible for that don't contract the scope of services, but they do reduce the payments for those services, which still continue to cost just as much as they ever did. These actions, then, place an indirect tax on all of the nongovernmental patients and others who support the local hospital, because it causes them to subsidize the medicare program; and I would say parenthetical to that remark that the hospital which I represent discounted over $7 million worth of care on medicare patients last year alone.

We believe that the medicare program should be held responsible to adequately pay for the services that are required for the people who are beneficiaries of that program. In the event that they cannot pay for those services, then we need to look at other ways that the beneficiary can receive proper care. Unfair cost shifting to other patients should be eliminated, and we possibly would get some reduction in demand. It's a very great problem for us, because we would never turn anybody away, and yet at the same time we are not getting paid in our hospitals for the services that we actually give. So now, with this new program coming in, there is apprehension because of the changes that would be implemented when we will get a predetermined amount for each diagnosis. You have no way of telling when an older patient comes in a hospital with a broken hip whether that patient is going to have a few other problems, too.

So the payment system that is being imposed on us and which started in October of this current year has a lot of problems in it. Some of the interim final rules that would govern the payment system over the next few years have some issues in there; and while these have not all been finalized, it is expected that they will be adopted then without a lot of major changes. I'd like to summarize just a few minutes, because I know you listened all afternoon, and I also know you read the paper, so you probably are aware of a iot of what I'm going to say.

I guess it's of concern to us, before I even say what those things are, that within the first month of administering this new program, the Senate Finance Committee considered a freeze or a cap on the DRG payments; and this is really an incredible intrusion on nonprofit hospitals, who are unable to plan and budget properly because our fiscal years are not the same as the Government's fiscal years, and then we really run into problems. We object to a freeze or caps put on future payments when we've been told one thing and then the Government decides that they're going to cut it even further.

The rules do not permit the hospital to bill the patient for any services provided after a utilization-review committee has determined that the patient's stay at the hospital is no longer necessary. The hospital cannot notify the patient by letter and say: "I'm sorry, your medicare payments have expired." Nor can we bill them for it, and so we're caught. We need to take care of the patient at the same time the patient's money has run out, and we can't even tell the patient that. To permit the patient to stay in the hospital, as the new rules would do, when the stay is no longer necessary is to condone wasteful utilization of health-care resources.

The Iowa Hospital Association is concerned that the new prospective-payment rules will disrupt the transferring of patients between hospitals, because the only hospital that gets paid is the one that the patient is discharged from; so if the patient is in a small hospital for 3 days and then it appears that the patient needs to go to a larger hospital, it's the hospital that discharges the patient that gets the payment, and not the other one, or it will get only a very small part of that.

So we've tried to cooperate with each other, but these new rules are not helping us. The new rules do not recognize, either, the differences among hospitals. In Iowa, we have a very complex system, because we're both rural and urban. We have primary-acute-care hospitals, secondary-acute-care-referral hospitals, and tertiary hospitals. Some of these are in rural areas, and then their payment is going to be according to the rural and not according to the urban categorization, which makes it extremely difficult.

Another complex area of the rules has to do with changing the billing methodology for nonphysician services, and a few examples would be orthopedic appliances and ambulance services. Those are some of the nonphysician services that are supposed to be rolled into the patient's hospital bill, and the hospital is being asked to be the billing agent for these nonphysician and, to a certain extent, nonhospital services.

I'd like to also point out that the blend of payments is another factor that we're concerned about. It is proposed that within the next 3 years we blend all payments so that everybody across the United States be paid the same amount. That can work in an adversarial way. We believe that the computation of the blend of the hospital's specific portion of the DRG price and the national portion should be computed according to the hospital's cost-reporting year and not according to some national average that's arrived at.

A major question of the prospective payment system is whether the Federal Government will adequately compute the DRG payment rate for both the costs of wages in the urban and rural areas and the costs of other services. In the paper from the Iowa Hospital Association, there was quite a bit of elaboration on that, and I think I'd like to summarize that by saying that hospitals have real obligations to try to keep their costs as low as they can. Approximately 50 percent of our costs are in labor. We do try to get a balance between full- and part-time people so that we can provide flexible staffing. But the provision for labor costs within the new DRG computations does not recognize that adequately, in our opinion. So, to assure fair, equitable, and adequate payment, the medicare program must assure that it is accurately determining wage-and-salary costs which are attendant to providing acute care.

Then let me see. There are a couple of other things about the payment rates here. There's a significant difference in payment for rural hospitals and urban hospitals, which is rather artificial, because most hospitals in Iowa are in competition for workers and pay similar wage rates. If adequate payment rates are not used to compensate hospitals, then we're not going to be able to provide quality available and accessible health care to the beneficiaries. The survival of many rural hospitals is really threatened by this new legislation and the enactment of the prospective-payment system; and, as you know, when patients don't receive care at the time they need it, then they generally become more costly because the time of treatment has been postponed. We're concerned that the economic policies which are attendant on this are going to be rationing health care in a way that puts hospitals in a position of making societal judgments of who is and who is not to receive treatment, and budgetary considerations and restricted accessibility with less providers will be the mechanisms used to control medicare program spending.

A case illustrative of this is the skilled-nursing care availability in the State of Iowa. I think you know, as has been demonstrated many, many times, that the Iowa medicare beneficiary does not have access to skilled beds like the medicare patient does in other States. Providers of skilled-nursing care reduced their beds available many years ago, and the beds have never been restored into service. Many hospitals in Iowa would like to provide skilled-nursing care if the payment rates were reasonable and if the hospitals would not suffer financial hardship if that care was furnished. Now for hospitals that are 50 beds and under there is a swing-bed method of payment, but that provision is not available to hospitals with more than 50 beds. We could encourage your support of a positive step to provide skilled care to patients all over the country, actually, by expanding the number of health-care providers who could provide that less costly care; so that for our larger hospitals which are over 50 beds, if we could have some provisions that when a patient moved from an acute level of care into a less acute level and it qualifies for skilled care, that we could move the patient into that type of care and have the reimbursement given to us for skilled care. Presently that's not available to us.

Iowa hospitals do serve in the public interest, and we will continue to do that. We are as concerned about the cost of health care as anyone is, and we want to continue to keep our costs below that of the national average, which they are now, and in line with hospitals in neighboring States. We want to continue serving medicare people. We do not want to underserve them and, therefore, would caution people who are charged with the medicare program that politically expedient decisions should not be made. Rather, appropriate factfinding, such as you're doing today, should be conducted and well thought out. Then appropriate considerations, which are based on considerations for all of society, should be, and can be arrived at.

I think I've said an awful lot here, and I know you're aware of much of this, but I do want to thank you, really, for allowing time for me to address this forum on behalf of the Iowa Hospital Association; and if you do have any questions that I could respond to, I'd be very happy to try to do that.

Senator **Grassley**. I will start with a very easy one. The first question I want to ask both of you, in regard to examing the causes of inflation, with the goal of getting inflation and health-care under control, what type of cost-containment measures do each of you feel is appropriate and would offer true progress in getting health-care inflation under control?

Mr. **Linden**. Do you want me to take it first?

Sister **Burns**. You're welcome to start out.

Mr. **Linden**. Well, I suppose that proper utilization of the facilities would be one methodology; and again, I think it's been alluded to today that there is more use of outpatient services—and I think we're seeing a trend somewhat in that direction.

Sister **Burns**. I think, too, that hospitals have to begin to look at themselves as health-care institutions and not just acute-care institutions. Some of the things that we can and should do—and I think that's where we need a lot of support, Senator Grassley—is on the development of a continuum of care for our elderly people so that they're in the hospital for that acute episode, but they also need to move to a less acute level of care. That's the skilled nursing care. We also need to make sure that they can be cared for at home, and we need the support for the home-health-care program so that nurses, physical therapists, and others can go into the home and provide this care, which is certainly much less expensive than an acute-care hospital.

Another facet of that would be such matters as day-care centers for the elderly, places where people can come and spend the day, every day of the week or several days of the week, and whatever can be done to enable our senior citizens to stay healthy in their own homes.

I think the hospitals really have a responsibility, as probably in most instances in most of our communities they are the one resource of all of the health-care personnel who could assist people when they are not in the hospital itself. So I think that we need to broaden the scope of responsibility for our health-care institutions and get the proper kind of reimbursements. Then I think we'll be able to do those kinds of things. I think we have the skill. We have the expertise, but we simply can't do it for nothing. So it's going to take a combination of things.

Senator **Grassley**. Both of you, in your answer, seem to put the emphasis upon the capital costs or the nonlabor costs. Is that the direction you think that we should be heading, and do you see the prospective-reimbursement system contributing to that goal or harming it from the emphasis you put upon cost containment?

Mr. LINDEN. I see more of that service being utilized under PPS. Do you agree?

Sister BURNS. Yes.

I think that hospitals have made major investments in their respective communities, and they've made those on behalf of the community, so that the community needs to help them pay for that, in a sense, and I say that, having just finished a building program. But I think that we need to have sufficient reimbursement to not only pay our debts but also to improve health care. So the prospective payment system in itself is not such a bad idea. In fact, you can say, well, we're going to have *x* number of patients and we pretty much know what kinds of diagnoses we're going to have, and so forth. All we're saying is, we should be paid for the kind of care that we give, and then we also should work with you to find other ways of providing care for patients when they are ready to leave our acute system.

We've discovered in health care these days that we do not have to keep patients in the hospital for as extensive a stay as we did at one time. The problem is that we don't have anyplace else for them to go, and so they stay in there, using these very expensive services, when actually they would be glad—and so would we—if they could get those services elsewhere, or we could provide them if we could be authorized to do that.

Senator GRASSLEY. That brings me to a question similar to one I asked the first panel, and that's the alternatives to the traditional health providers. I mentioned the CRNA's and also the physicians' assistants. Do you see that as one way of holding down costs? Do you see it as compromising the quality of care?

Sister BURNS. CRNA's, you're talking about the nurse anesthetists?

Senator GRASSLEY. Yes.

Sister BURNS. I think it depends on what you're trying to do as to the level of professional care that you would give. In the acute-care situation you would certainly want to have an anesthesiologist, who is a physician that has had special training in giving anesthesia, and who can supervise, then, a registered nurse who has special training; so I'm not sure that that in itself would cut health care costs. Physicians' assistants do help physicians. We haven't had a lot of experience with physicians' assistants in the State of Iowa, so I would decline to make a comment on whether they would contain health care costs. I'm not sure that they would. I'm not saying they wouldn't, but our experience has not been wide enough with them to really make a statement on that. Certainly it's a possibility.

Senator GRASSLEY. When you mention your experience hasn't been very good, I can recall back—I think it was either 1969 or 1970—when a State representative by the name of Vincent Mayberry from Fort Dodge sponsored and got passed a physicians' assistant bill for the State of Iowa. Very few in the State legislature at that time were opposed to that, and, in fact, we looked at that as being a major solution to some of our health care costs. But more importantly, we saw the bill as filling a void that family physicians could not fill, because we hadn't yet graduated enough physicians, and we had just started that specialty at the University of Iowa.

Although I am not shocked by your response, it seemed to me like somewhere along the line we haven't caught up with what public opinion was a long time ago.

Sister **Burns**. I think at the same time as that legislation that we were increasing the numbers of people in medical school; and now there are enough, and in some people's opinions, too many, physicians in the United States, and therefore, it is not likely that they will move along the line of getting physicians' assistants, or at least it has not been a popular mode of delivering care in this part of the State. Now, I don't know.

Mr. **Linden**. Obviously, I go along with it.

Sister **Burns**. Those that we do know of have been very fine, you know.

Senator **Grassley**. I don't worry too much over the fact that perhaps we are producing too many medical doctors, whether it's in Iowa or the entire Nation. Again, referring to the period of time when I was in the State legislature, according to statistics that were put out by the board of regents, we were paying almost as much to educate Ph.D.'s at the University of Iowa, and at Iowa State University, as we were paying to educate medical doctors. At that time, the Carnegie Institute was putting out figures indicating we were graduating about 330,000 Ph.D.'s a year and had jobs for 9,000. We didn't worry about the overproduction of Ph.D.'s. Why do we worry about the overproduction of medical doctors? Maybe there's a good reason, and maybe I should be more receptive to those reasons, but I don't buy that rationale.

Mr. Linden, did you have any comment on the question I asked about alternative providers of care?

Mr. **Linden**. No; I agree with what she said.

Senator **Grassley**. You agree with it.

From the standpoint of Blue Cross/Blue Shield, Mr. Linden, being involved both as a provider as well as an administrator for medicare, you are in a unique position to see whether or not recent changes result in the shifting of costs.

Do you think things Congress has done so far resulted in the shifting of costs to private pay people and also to private health insurance?

Mr. **Linden**. Well, there has definitely been, in a lot of areas, shifting of costs; and I think it affects different providers differently. Some have experienced that shift to a greater degree. Again, in a prospective payment system, it's too early to tell if there is going to be a shift of cost.

Senator **Grassley**. I don't suppose too many people would agree with this, or even if they did, they might not want to admit it, but Senator Heinz, chairman of the Senate Special Committee on Aging, held a hearing on cost shifting, and there were a tremendous number of comments from people who had studied health care costs and cost shifting to a considerable extent, who said that cost shifting is really necessary. That is, everybody at the grassroots needs to be impacted before you're ever going to get the political pressure, and the political will to actually do anything about health care costs. I think they were basing that statement upon the five or six States that have had some cost-containment legislation, and then evidently some cost shifting. When the realization of cost shifting finally got down to that last person who was paying the bill and he was screaming loud enough, then there was a political will expressed through politicians or legislative bodies to do something about it. I would hope that we don't have to do that.

I've even expressed the view that we shouldn't have cost shifting, but perhaps it's not realistic to think in terms of having no cost shifting occur. But obviously we would hope to limit it.

One area I haven't brought up today concerns malpractice insurance and the protection it takes to avoid malpractice suits. That brings us to the question of whether or not there is too much expense being foisted upon the system to avoid malpractice suits, such as extra tests, and so forth. Do you feel malpractice considerations do affect health care costs and the use or overuse of expensive medical technology?

Sister BURNS. Yes.

I think that doctors almost have to practice defensive medicine in many ways. I'm not saying they do unnecessary testing, but I think that numerous lawsuits have indicated, well, the doctor didn't test for this and the doctor didn't test for that; and so they decide that they will be sure to rule everything out or do a complete workup. I do think that that has contributed a number of legal actions that resulted in awards to the plaintiffs, which in turn have made physicians more and more wary of the malpractice issues. In fact, at the present time there are some malpractice issues which involve medicare. Our particular group of hospitals is involved in an appeal on how medicare is treating the cost of malpractice.

At one time we were reimbursed based upon our malpractice cost, how much does it cost us to just make sure we have enough insurance; and now medicare has changed that regulation so that it's based on an average of claims paid. So if you weren't sued or you didn't have to pay out a claim, then your reimbursement is changed. But that doesn't make any difference. You're still paying an awful lot of insurance costs, and medicare has been disallowing that. So it seems that the hospitals need to be paid for the malpractice costs based on the number of medicare patients that use the hospital in a given year rather than on how much they paid out; so there is some issue there with malpractice costs that penalize the hospitals to a certain extent. We provide the testing for the patients, and yet if a malpractice case comes along, we want to make sure that we're protected. So we pay some very heavy insurance costs for that protection, and yet we don't get reimbursed for that unless we get sued, which seems kind of bad. I mean, we don't want to get sued, but you know what I mean. It catches you.

Senator GRASSLEY. Do you have anything to add to that, Harold?

Mr. LINDEN. It's only as an intermediary we have to follow the guidelines in the steps we take in allowing settlements or disallowing costs.

Senator GRASSLEY. I have one last question. Who is going to really decide some of the tough questions, of who is going to get the care and who isn't? That question has been asked for a long time. It is even more important now with artificial hearts, organ transplants, and all the new medical technology. Who do you want to decide what services medicare patients can receive and at whose expense? Doctors occasionally ask me that type of question as if it's a political question, and we ought to have the answer. Who do you feel should, or is going to decide such delicate issues?

Sister **Burns**. I think we all want the very best of everything when we're sick or somebody close to us is sick, and one of the great fears I think we all have with this tightening up of reimbursement is that we will stifle the advancement of medicine, that because we will restrict ourselves so much to just doing what we absolutely have to do, that we will not be able to progress the way we should. Now, who should decide, really? In many ways that's a personal decision between a physician and his patient or her patient, as the case may be, and I think oftentimes that hospitals and persons like yourself are caught with having to make decisions about—well, as Victor Fuchs said in his book, "Who Shall Live?"

There are only so many resources to go around. Have we bought ourselves an agreement that we cannot realize, or have we put our priorities in the right place? Occasionally you hear people get very upset that 10 percent of the gross national product is going to health care. Well, I guess you have to ask, then, is anything wrong with that, if that's where the American public wants to put its money? Is that any worse than putting it in bombs, nuclear warheads, or whatever?

I really think that society has to ask those questions. Hospitals and physicians are really here to serve people when they're in a moment of need, and our motivation is not to get rich quick but to take care of people. But we are caught, at the moment, between great demands for health care and yet an inability to provide all that we would like to, because we are not receiving the payment for it.

So, that's our problem, and we're trying to resolve some of that by really looking at some of the things I mentioned earlier, which are things that would help our patients move more rapidly from that acute-care level into another level of care; and I think we can do that, and I think we can help contain some of the costs. But when we do that I think we also have to be mindful that there are still new frontiers out there, and we don't want to lose the ability to develop further. I know that doesn't really answer the question. I'm not sure anybody really can. Maybe, Harold, you've got an answer for that.

Senator **Grassley**. I don't see too many people clamoring for your State senators to answer that question.

Harold, did you want to comment?

If you don't, I want to close the meeting.

Mr. **Linden**. No, thank you.

Senator **Grassley**. I want to thank you two as members of the third panel and also express disappointment that Dr. Rhodes couldn't come, but I understand.

Sister **Burns**. Thank you.

[Subsequent to the hearing, Senator Grassley submitted a question in writing to Mr. Linden. That question and Mr. Linden's answer follow:]

QUESTION TO HAROLD W. LINDEN

After enactment of the hospital prospective payment system, some attention has turned to expanding the system to all payors or providers. I know Blue Cross/Blue Shield of Iowa has developed a type of prospective payment system. How does your organization view the potential for expanding medicare's prospective payment system?

Answer. We believe that expansion of our present system to a DRG type of program may be a natural progression as the DRG method is refined, and as we gather comparable data on the private-pay population we serve. We do believe, though, that this may be several years away.

Senator **GRASSLEY**. Considering we had one accident today, I think it's pretty good that people got here. I want to thank everybody for attending, particularly those who had a difficult time in getting here. Maybe that's everybody. It isn't the best weather to have a hearing, and yet we had an outstanding turnout. I want to thank our excellent witnesses who took time out of their busy business and professional schedules to be here.

As I said previously, the record will remain open for approximately 15 days for correction or insertion of additional material. As I said at the opening, we have made provisions for anybody who wants to submit a statement in writing to be included in the record. That's to take care of those people who perhaps wanted to testify but were unable to testify. We also have comment sheets available for people even if they had no anticipation of testifying.

This hearing was held in Sioux City. I suppose it could have been held in a lot of other cities in Iowa or South Dakota, because there is a desire on the part of Senator Heinz and Senator Dole, who are both very much interested in these hearings, in getting grassroots opinion.

I want to thank everybody for coming. The meeting will be adjourned. I want to suggest, if anybody wants to follow me to Hinton, Iowa, I've got a meeting from 4:30 to 6 p.m., in which we'll discuss anything—not just health, but anything of concern—and then from 7 until 8:30 p.m., in Orange City. Then I'll go to Rock Rapids tonight where beginning at 8 o'clock in the morning I'll have a meeting until 9:30 a.m., of a similiar nature, where any subject can be brought up and discussed unless you're mad at the State legislature. I can't do much about that.

Meeting adjourned.

[Whereupon, at 4:15 p.m., the committee adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1. STATEMENT OF JOHN M. RHODES, M.D., IOWA MEDICAL SOCIETY

I am John Rhodes, M.D. I am a family physician in Pocahontas, Iowa, and the Iowa Medical Society's senior delegate to the American Medical Association. The Iowa Medical Society appreciates the opportunity to present its views to this hearing, "Crisis in Medicare: Proposals for Reform," sponsored by the Senate Special Committee on Aging. The Iowa Medical Society represents over 3,200, or approximately 90 percent of Iowa's physicians.

The Iowa Medical Society recognizes the magnitude of financial problems facing the medicare program. We note the Congressional Budget Office indicates the health insurance trust fund, which is financed entirely by payroll taxes, could, without changes in current law, be depleted by 1988 and, by the end of 1995, have a cumulative deficit of $300 billion. The Congressional Budget Office also indicates outlays for the supplementary medical insurance trust fund, which is financed through enrollee premiums and appropriations from general revenues, will increase by nearly 16 percent per year through 1988.

The American Medical Association also recognizes the magnitude of this problem. The AMA has initiated two efforts designed specifically to address many of the concerns that are before the Senate Special Committee on Aging. First, the association has begun an in-depth review of the medicare program to determine what if any changes are needed to keep the program solvent. In this analysis, the AMA will be considering various proposals that have been suggested by others, including initiatives for increased revenues; modifications that would decrease the number of eligible beneficiaries; provisions that would reduce benefits and provider reimbursement under the current program; proposals that would establish a relationship between benefits received and beneficiary income; and proposals to change the way in which services are provided under the medicare program.

On a broader front, the association has made a major commitment of time and resources for an evaluation of our entire health care delivery system. To this end, the AMA has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that can be responsive to the particular social, economic, scientific, educational, and political issues and circumstances facing health care decisions. Six work groups have been organized to develop principles and action plans in the following areas: medical science, health care education, health resources, health care delivery mechanisms, evaluation and assessment, and payment for health care services.

The first phase of this project, the development of principles, is scheduled to be complete soon, and the work groups will then turn to the development of action plans to carry out the principles. This activity involves approximately 150 organizations, including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurers. Through the activities of this broad-based organizational body, we hope to be able to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

The AMA expects that the health policy agenda project will look at the cost of providing health care services, and we expect that this body will come to grips with many of the same issues facing this special committee

The Iowa Medical Society recognizes the need to address numerous options for medicare, including reductions in reimbursement to providers, changes in benefit structures, beneficiary participation in financing, and tax issues. We have not given sufficient attention to tax issues to discuss them with you today. I do hope, however, to convey the views of the Iowa Medical Society on several options which have been put forth previously.

I emphasize from the outset the concern Iowa physicians have for the maintenance of a high quality health delivery system that is accessible to all citizens. In this regard, I will comment on our concerns relative to the recent implementation of a prospective payment system for hospitals providing services to medicare beneficiaries, according to diagnostic related groups (DRG's).

Under cost-based reimbursement, the hospital and the physician who worked with the patient to determine the course of care received had an incentive to provide all appropriate health care services, since payment was made for all necessary and appropriate services provided to program beneficiaries. However, this will no longer be the case. The DRG payment system reverses this incentive and can instead assure the hospital of a profit in situations where services are reduced. In the impact analysis of its interim final rule, the Health Care Financing Administration (HCFA) asserts that:

"We anticipate that quality of care for beneficiaries will be maintained or improved. Quality of care is protected in a number of ways separate from this regulation, and results of several recent studies indicate that prospective payment programs operating to date have not compromised the quality of care provided in hospitals, even while such programs generally reduce the intensity of care provided to patients."

The Iowa Medical Society disagrees with this analysis, especially since the "recent studies" were not based on the program now being initiated. This regulation is untested and, even when coupled with the new professional review organization (PRO) program as is currently being developed by HCFA, may be inadequate to assure the maintenance of quality standards in American hospitals.

The unsubstantiated assertion that the quality of care has not been compromised in States that are currently under rate review or other prospectively determined payment methodologies is simply incorrect. According to the recent study by the Congress of the United States, Office of Technology Assessment (OTA), "Diagnosis Related Groups and the Medicare Program: Implications for Medical Technology," July 1983, both New York and New Jersey experienced a reduction of availability of complex services, and the service that was hardest hit by the ratesetting programs was medical social work services. The fact that medical social work services were hardest hit by the cutbacks in reimbursement is particularly worth noting as the impact analysis indicates that quality of care will be assured by means other than the prospective payment regulations. HCFA is currently analyzing a proposal to revise the conditions of participation for hospitals, and the revised conditions would actually delete the conditions for medical social work services in the hospital setting. In addition, the proposed conditions would leave surgical services, anesthesia services, rehabilitation services, respiratory care, nuclear medicine services, outpatient services, and emergency services as optional services that a hospital could provide. We are very concerned that with the perverse incentive to not provide services, access to such optional services will be increasingly more difficult for patients who could benefit from these services.

Given the incentive to provide the least possible care, the Iowa Medical Society is particularly concerned with the possibility of a paring of nursing services for medicare beneficiaries. This concern is based on the fact that nursing services generally constitute the largest single element of a hospital's budget, and it could be the target for cost trimming. We recognize that a significant benefit patients receive in the course of hospital care is provided by the nursing staff, and reductions in this care can only have a negative effect on medicare beneficiaries. Given the recent elimination of the nursing differential, and the new economic pressures hospitals will face, the potential for a negative impact of the prospective payment program on nursing services is very real, and it must be closely monitored as an element of quality health care services.

Aside from the provision of basic services, another element of quality that could be jeopardized is the development and use of medical technology. While this technology can be expensive to provide, no one can doubt that the availability and application of services such as computed tomographic scanning have significantly improved the quality of care available to all hospital patients, including medicare beneficiaries. This service has reduced patient risk and discomfort, while simultaneously providing more extensive diagnostic information. The OTA report concludes that:

"Though DRG payment does not imply that technological change wil approach a standstill, its directions are likely to be altered, and the adoption of technologies that are cost-raising to the hospital is likely to decline by an unknown quantity."

This concern is particularly relevant in relation to diagnostic radiology. The next generation of scanning devices, the nuclear magnetic resonance scanner, is now being introduced into hospitals. It provides significant new diagnostic information, further decreasing needs for invasive procedures and reducing patient risk and discomfort. Will institutions be able to install and afford to operate this type of equipment under the new payment system?

There are no assurances that the development and availability of medical technology will continue under the new payment methodology. The Iowa Medical Society is particularly concerned about this fact because situations are likely to arise where patients will be in need of necessary services that a hospital simply will be unable to provide. This is especially critical when a patient would be at severe risk if transferred to a hospital with the necessary equipment. Quality would be adversely affected if an unnecessary delay caused that patient to be transported in an unstable condition or subjected to a more invasive or risky procedure.

Under the prospective payment system, hospitals have a strong economic incentive not to provide services. Because of this, they may exert pressure on physicians to discharge patients prematurely or to withhold some medically indicated services. Also, if a hospital has reduced the level of services, all medicially necessary services may not be available to medicare beneficiaries. Because of this, PRO's should play an important role in insuring that quality medical care is provided by supporting physicians in their decisions to continue medically necessary care. While Congress recognized the essential role of the review agent in the prospective payment system, these regulations fail to provide such a mechanism. The Iowa Medical Society recommends that a PRO should have the authority to review cases based on an individual physician's request. Without such a safeguard, patients and their physicians will have no recourse to assure the provision of quality health care services.

We must also point out that hospitals will be hesitant to transfer patients under this payment system. Because they incur the greatest percentage of their costs in the early days of a stay, and with the payment for a transferred patient based on a per diem for the applicable DRG, hospitals face a disincentive to having patients transferred. With the likelihood of hospitals losing money on patients who are transferred to a second facility, will patients in need of care that is unavailable in the treating facility have access to the appropriate level of care?

We must caution against implementing additional changes to accomplish immediate and expedient savings in health programs (such as the recent implementation of DRG's for medicare hospital inpatients), that would result in some savings but have the concomitant effect of limiting access and availability of health care for those very individuals for whom the Federal Government assumed a primary financial responsibility. For example, in creating the medicare program in 1965, Congress committed itself and the Nation to providing access to high quality care for the elderly. That promise, to a large extent, has been met. The 17 years since enactment of this program have seen a tremendous improvement in the health status of the elderly. This is a result of which all Americans can be proud.

Yet the medicare program has been the target of an unending stream of cuts. It must be remembered that the increased costs result in large measure from the very success of the program. It is a striking phenomenon of the American scene that the elderly represent an increasing percentage of our population, and it is the fastest growing segment of our population. In 1965, the medicare rolls totaled 17 million; today the number is 28,700,000. Moreover, life expectancy has increased so that the expected lifetime span is now over 73 years and expected to increase further over the years. The vital statistics for our Nation also tell us that the percentage of "old-aged," i.e., those over 85 years, is also increasing with greater requirements for medical services. In addition the quality, and consequently the cost, of care has increased with dramatic new technology. Improved access and services have added to the costs.

I point these factors out, Senator Grassley, to put in perspective the frequent charges that the current high cost of the programs is caused by high charges in the delivery system. It is true that increased costs and charges for services also contribute to the high costs of these programs, but there are many factors involved.

For example, a review of health care costs in this country cannot be divorced from the fact that the mix of services available involves more sophisticated technology that is being continually updated. While improved methods of treating patients through new technologies cannot guarantee the provision of quality health care services in all instances, it cannot be denied that expenditures for technological advances have served to improve the overall quality of health care that is available.

An example of a technological breakthrough that has virtually revolutionized the field of diagnostic radiology is the use of the computed tomography (CT) scanner.

The use of CT scanners has dramatically changed the means of treating many patients. Improved imaging technology has greatly reduced the use of more expensive, more risky and uncomfortable invasive procedures. While the initial costs of this equipment caused great concern, it was soon realized that this technology was an important improvement in patient care. Yet even today, while CT scanners have started to become commonplace, they are becoming obsolete. The Food and Drug Administration is currently in the process of considering whether or not to grant marketing approval for a nuclear magnetic resonance imaging device that takes clearer, more detailed pictures than even the latest model CT scanner. This is just one example of the evolutionary process and concomitant expense that is inherent in the development and use of medical technology.

The Federal responsibility for health care coverage through medicare and also total health care expenditures will continue to increase over time as the population and elderly population in particular increases. There will be substantial increases in the elderly population over the next 50 years, and this is particularly important as the elderly have historically utilized a greater proportion of health care resources. From 1950 to 1980, the population in the United States of individuals over the age of 65 doubled from 12,334,000 to 25,544,000. Projections through the year 2030 indicate that this population will again double, reaching 36,251,000 in 2000 and 64,925,000 in 2030. In addition, an article from the March 1983 issue of Health Care Financing Review points out that the population of those over age 75 is projected to increase four times faster than the population of those under 65.

In 1978, the average per capita expenditure for health care by individuals who were medicare eligible was $2,026. The significance of this figure is illustrated by the fact that per capita spending for individuals between the ages of 19 and 64 totaled $764, for individuals under 19 the figure was $286, and the average for the combined group was $753. The statistics also indicate that individuals over the age of 65 are more likely to be hospitalized than those under that age, they use more hospital days per hospitalization, and they visit their physician more frequently. The importance of these figures is clear: as the population ages, demands for health care dollars will correspondingly increase.

The most substantial element in the growth in expenditures for health care from the period of 1971 to 1981 has been the general inflation besetting economy. According to an article published in the March 1983 issue of Health Care Financing Review, general inflation "accounted for approximtely 57 percent of the increase in total systems costs (personal health care costs) for the period 1971 to 1981." In addition, approximately 8 percent of the growth in expenditures is directly attributable to the aggregate population growth over that period of time.

The United States may have reached a point in its history where sustained economic growth can no longer be maintained and limited resources will force the necessity of facing difficult choices. As witnessed by the total revamping of the methodology for payment for hospital services under medicare, this Congress has established its willingness to reduce resources devoted to health care. However, we urge caution so that changes made today do not place in jeopardy the continued availability of quality health care for future generations.

The medical profession is dedicated to the provision of the best possible care available to patients in need of care. In the past, this dedication has run up against ethical considerations based on the availability of resources necessary for the provision of optimal care. A classic example of this dilemma that was finally resolved through the legislative process is the development of the end-stage renal disease (ESRD) program.

Prior to the enactment of the ESRD program, decisions to provide dialysis services often revolved around the availability of such services, as there were shortages in renal disease equipment, trained personnel and treatment facilities. Decisions as to who would be availed the opportunity of treatment were being made by ad hoc committees. These committees, by necessity, made life and death decisions. Such committees became unnecessary in 1972 when Congress provided coverage under medicare for people suffering from chronic renal disease.

The effect of this decsion by Congress was the expansion of a specific medical technology to all of those in need of it, but at a substantial cost to the Federal Government. In 1974, when the program was initiated, it covered approximately 18,400 individuals at a cost of about $230 million. Presently, the program serves over 70,000 patients at an annual budget of almost $2 billion.

Senator Grassley, while there is little disagreement over the fact that the ESRD program is an expensive one (renal patients represents approximately one-fourth of 1 percent of the medicare beneficiaries, but they consume nearly 10 percent of the medicare part B budget), it is extremely doubtful that individual program beneficiaries, their families and friends would object to the program's expense. Nevertheless, it is just such expenses and such programs that illustrate the considerations that are inherent in decisions made in the name of health care cost containment.

The idealistic goal of the midsixties, i.e., to place the elderly and the needy of this country in the mainstream of our health care system, is, as we approach the mid-eighties, becoming a myth. Reduced Federal support of the medicare program cannot be made without hurting patients by either restricting access to care or by forcing them to shoulder an increased share of the cost of their care.

Several specific proposals have been recently made with respect to medicare. Most are described as cost saving changes. We counsel thorough evaluation of these proposals with a critical eye on implications for quality and access.

The Reagan administration has proposed that physicians' reimbursement under medicare's "reasonable charge" system be frozen for 1 year. The customary and prevailing charge screens to be used for year 1984 would not be updated but would be kept at the levels used in fee screen year 1983.

The Iowa Medical Society opposes this proposal. Since the passage of Public Law 92-603 in 1972, annual increases in allowable charges under medicare have been restrained by several arbitrary factors. I will mention only two. First, payment was fixed at 75 percent of the prevailing rate for local charges. Second, any growth in the recognized "prevailing rate" was restricted by an "economic index" factor related to 1972 prevailing charges (which by virtue of a statutory lag time reflected 1971 actual charges). Furthermore, "economic index" allowances never really reflected actual increases in the costs of providing medical services.

A freeze is especially unfair in light of continued cost increases that physicians must face in their practice for which medicare reimbursement will be denied. Is the Federal Government now going to pay 1983 prices to all suppliers in 1984? The answer is obviously no. We believe that it is unfair to freeze the costs of one sector of the economy while not asking attorneys, architects, and other professionals to accept a freeze and while allowing prices paid other suppliers to rise.

Senator Grassley, physicians are not unaware of the financial circumstances of the patients. As an example, more and more patients are seeing physicians without any insurance coverage due to the current recession. Physicians all over the country are treating these patients free or for greatly reduced fees. Over 100 medical societies have organized programs to assure care to those in need.

The Iowa Medical Society is among such medical societies. Last year we instituted a three point program that suggests:

(1) Iowa physicians be open to working out special arrangements to help an individual or family who may be bypassing necessary and immediate medical care because resources are exhausted.

(2) Iowa physicians consider organizing temporary local programs, perhaps through county medical societies, to see that medical care is furnished where a financial need is identified and where government support is unavailable.

(3) Iowa physicians study their individual practices to see if and/or how their existing fees can be held firm or even reduced in the coming year.

At the present time, while 87 percent of physicians participate in the medicare program, 80 percent of them accept some claims on assignment. Over half of all medicare claims are on an assigned basis. The primary reasons why so few claims are accepted on assignment are administrative deterrents, paperwork, and inadequate reimbursement levels. The result of further reductions proposed by freezing any reimbursement increase would be an added disincentive to acceptance of medicare assignments. This could lead to increased costs to be borne by beneficiaries as the Federal Government further reduces its responsibility and the value of the program to the beneficiaries.

We urge that this proposal not be adopted.

The Reagan administration is also proposing that the Department of Health and Human Services use competitive purchasing procedures in procuring laboratory services, durable medical equipment, and other medical supplies.

Competitive bidding would be appropriate in the procurement of durable medical equipment and other medical supplies because of the nature of such products. However, cost considerations should not be the single deciding factor in procuring professional services related to the delivery of patient care. Physicians should be allowed to exercise their professional judgment in selecting qualified laboratory services for their patients, taking into account the quality of such services as well as their accessibility and cost. We cannot support competitive bidding for professional services.

We are also aware of proposals to mandate physician assignment under medicare. The Iowa Medical Society opposes mandatory acceptance of assignment.

In our view, a key to the high quality health care services available under medicare is the individual beneficiary's ability to seek his or her care through the free choice of a physician. Approximately 90 percent of all physicians (including pediatricians and psychiatrists) treated medicare patients in 1979, and with approximately 79 percent of these physicians submitting some claims on an assigned basis (AMA Center for Health Policy Research), beneficiaries are allowed a wide range of choice in determining who will be their attending physician.

Physicians participating in the medicare program have an option, on a claim-by-claim basis, to accept or not accept the medicare-determined "reasonable" charge as payment in full (assignment). The ability to charge patients in addition to the "medicare charge" recognizes the fact that the medicare program does not reimburse physicians at the usual, customary, or reasonable charge. The direct billing option prevents the low medicare reimbursement from precluding many physicians from participating in the program. Congress considered these matters in providing an assignment option.

Because physicians have a choice as to whether or not they will accept assignment, medicare beneficiaries are in turn able to select a physician from virtually the entire physician population. A change in the assignment policy, especially in light of proposals to further hold down medicare part B reimbursement, could affect the access of medicare patients to the physician of their choice.

Physicians consider a number of factors in deciding whether or not to accept assignment on a particular claim: the nature and expense of the service provided, past payment experience with the medicare carrier, the ability of the individual patient to pay for care on a par with non-medicare beneficiaries, and the relationship between the physician and the patient.

This last factor is particularly important, as it raises the point that patients should discuss whether they (patients) have a need for the claim to be submitted on an assigned basis perior to the initiation of the billing process. Statistics clearly point out the fact that most physicians are willing to accept assignment of claims.

Senator Grassley, the Iowa Medical Society recognizes that you and the Commission have heard about physician charges to individual patients that have exceeded the medicare allowable charge. However, such examples of charges substantially higher than the medicare recognized charge are the exception and not the rule. Indeed, physicians treat many medicare beneficiaries at a reimbursement level that is significantly below the usual and customary level of reimbursement. The following statistics for 1979 (generated by HCFA unless otherwise noted) detail the record of physician acceptance of medicare assignment.

In 1979, there were 26,454,000 people enrolled in the medicare part B program. Of this number, 2,621,000 people were eligible for the program due to disability. Benefits paid for the aged population equaled $6,903 million, and total benefits paid equaled $8,259 million. The total number of eligible aged enrollees who used physician services in that year equaled 13,443,800.

In 1979, 51.1 percent of all claims (aged and disabled beneficiaries) were assigned, and 50.7 percent of the total charges were assigned. Breaking these statistics down further, assignment rates increase in situations where average annual charges per user increase. While the percent of total charges that were assigned for aged medicare enrollees equaled 46.5 percent, this figure steadily increases as total annual charges per user increases.

Assigned charges as a percent of total charges

Total annual charges per user:	
$1 to $99	29.5
$100 to $149	28.8
$150 to $199	32.5
$200 to $249	34.6
$250 to $299	36.2
$300 to $349	38.0
$350 to $399	40.0
$400 to $499	41.6
$500 to $699	44.4
$700 to $999	46.1
$1,000 to $1,499	46.6
$1,500 to $1,999	46.2
$2,000 to $2,499	48.5
$2,500 and up	54.3

The percent of services assigned and the percent of total charges assigned similarly increase as beneficiaries grow older. This is particularly significant as per capita reimbursement for physician and other medical services increases with age.

Age	Reimbursements per enrollee	Percent of services assigned	Percent of total charges assigned
65 to 69	$187	43.7	44.4
70 to 74	213	44.6	45.5
75 to 79	241	47.3	47.9
80 to 84	253	51.0	51.2
85 and up	260	59.4	59.2
Average total	219	47.9	48.3

Liability for charges in situations where physicians do not accept assignment under part B falls to individual beneficiaries. While individual examples can be pointed about beneficiaries with large outstanding liabilities for services, the statistics clearly illustrate that most individual beneficiaries are not being faced with substantially high levels of personal liability for physician charges.

While it is reasonable to expect that the great percentage of medicare beneficiaries have some unassigned claims (78 percent), the personal liability for 83.9 percent of part B service users was less than $100 on unassigned claims. It should also be noted that total user liability for part B services does include 20 percent coinsurance and deductible figures ($60 in 1979), and that the dollar amount of liability for the 20 percent coinsurance will correspondingly increase with increases in the amount charged. For those individuals who used part B services in 1979, 64.9 percent of them had a total user liability of less than $150 each. The following chart sets out total user liability for individuals receiving part B services in 1979.

Amount of total user liability [1]	Average coinsurance liability [2]	Total percent of reimbursed users	Average reimbursement
0 to $50	$11	16.6	$44
$51 to $75	14	15.5	57
$76 to $100	24	15.3	95
$101 to $150	45	17.6	178
$151 to $200	78	8.9	311
$201 to $250	112	5.6	447
$251 to $300	145	3.7	579
$301 to $400	191	5.0	762
$401 to $600	270	5.4	1,079
$601 and up	514	6.4	2,055

[1] Including coinsurance and $60 deductible.

[2] These figures are based on the assumption that average reimbursement is 80 percent of the medicare recognized charge.

The Iowa Medical Society believes that the figures set out above show that the medical profession has an exemplary history of treating medicare beneficiaries on an assignment basis. This is particularly impressive in light of the fact that the medicare program has never reimbursed physicians at their usual, customary, and reasonable fee levels. In addition, medicare fees for physicians services have been subjected to arbitrary reductions through prevailing fee limitations and the application of the economic index.

The Iowa Medical Society is opposed to changes to the medicare program that will limit beneficiaries' access to care. We believe that the majority of physicians would continue to provide needed services to medicare beneficiaries even if reimbursement for physician services were altered through mandated acceptance of assignment or by other means that would lower physicians reimbursement under medicare. However, we are concerned that such changes could result in a growing number of physicians who will not participate in the medicare program.

The existing system where physicians have an option as to whether or not they will accept assignment has not, as the figures indicate, resulted in beneficiaries facing substantial out-of-pocket costs as a result of physician charges above the medicare recognized "reasonable" charge. Indeed, the fact that over 50 percent of all claims are assigned and that over 50 percent of the total charges were on an assigned basis in 1979 points to the fact that case-by-case determinations on whether or not to accept assignment allows the charge for services to be molded to fit the individual situation. Furthermore, the figures for acceptance of assignment have been steadily increasing: in 1982, 52.8 percent of all claims were on an assigned basis, and 54.2 percent of total charges were assigned. It must also be remembered that the medicare program was created as an insurance, not a welfare program, and that a large number of medicare beneficiaries are of substantial financial means. In light of medicare's policy to reimburse physicians less than their actual fee, we do not believe that it is appropriate to cost-shift private patients a subsidy for all medicare beneficiaries, regardless of the beneficiary's financial condition.

We must, however, point out that if Congress believes that more widespread acceptance of assignment is a beneficial goal, this goal could best be accomplished by making the reimbursement level under medicare more acceptable and in accord with usual and customary practices, and by expediting the billing and claims process. The fact that such changes would increase acceptance of medicare assignment is borne out by the fact of physicians not accepting assignment in 1982, 60 percent report that insufficient reimbursement was an important reason, and 36 percent say paperwork was an important reason (AMA Center for Health Policy Research).

We are also aware of proposals to establish caps on increases in revenues for all hospital inpatient services, as well as caps on charges for hospital outpatient services and for all physician services. Some advocate systemwide changes in the delivery of medical care to slow the growth of medicare outlays. Placing controls on hospitals and physicians would be highly discriminatory against one segment of our economy. We believe such proposals should be opposed.

Proposed limits on hospital revenues would contravene the intent of Congress to provide incentives for hospitals to improve the management and delivery of their services. The prospective pricing system, enacted as part of Public Law 98-21, establishes a system whereby hospitals which perform services for less than the fixed cost-per-discharge will be able to retain those resources, and whereby hospitals that have costs beyond the fixed cost will have to absorb the differential. Rather than encourage improved management of hospitals, revenue cap proposals would, in fact, lock hospitals into their existing cost structures, rewarding inefficient hospitals and penalizing those hospitals that have taken good faith efforts to reduce costs and improve their management capabilities.

Revenue caps are especially cumbersome in light of the dynamic nature of medical technology and the mobility of the population of the United States. Such a system would, by its very nature, require extensive exceptions procedures to allow for legitimate changes in patient-mix, new technology, and population shifts.

We do not believe that a proposed cap on hospital revenues should be enacted. We believe that Congress has already set in motion, through enactment of its prospective pricing system, major changes that will affect the way in which hospitals provide services and the cost of those services. It should also be noted that private insurors are now also looking toward prospective pricing for hospital services. To place arbitrary revenue caps on top of a rapidly developing system could inappropriately affect changes now under way. Finally, Congress has substantially modified the hospital reimbursement system under medicare during the last two Congresses. The leadtime for implementation of the prospective pricing system has been extremely short. As a matter of fact, the system is still not operative and will become effective in just 3 days from today. Continued congressional tinkering with the hospital reimbursement system could force hospitals to expend increased amounts of resources to cope with constant changes in the reimbursement systems, at the expense of patient care. The central focus of a hospital should be patient care—not how to deal with continuous changes in Federal reimbursement policy and proposed controls.

Senator Grassley, we are aware of proposals to place all physician fees for medical service under the control of the Federal Government. The Iowa Medical Society opposes arbitrary caps on professional service fees in all sectors. We believe arbitrary fee caps are counterproductive. It is expecially unfair to single out physicians for strict regulation of fees when the charges of most other professionals continue to increase, free of all controls. This means that physicians would be faced with restraints on their charges, but there would be no such restraints on the rest of the economy.

There are a number of proposals relating to beneficiaries of interest to the Iowa Medical Society. First, however, I would like to comment on a Reagan administration proposal which provide that medicare beneficiaries be given the option of enrolling in private health insurance plans. The Federal Government would pay to the insurance plan chosen by the beneficiary an amount equal to 95 percent of the adjusted per capita costs of the medicare program. Private plans would have to provide coverage at least equal to that provided by medicare to be eligible. Beneficiaries who opt for the voucher plan would be permitted to reenter the medicare system. If the private plan alternative costs less than the voucher amount, the beneficiary would be entitled to a cash rebate.

The Iowa Medical Society cannot support this proposal. The concept of a medicare voucher has been discussed over the last several years. Key questions about such a proposal are, of course, will it save any money and will it work? We believe that the lack of known answers to these questions is the reason why the proposal has not been accepted in the past. Quite simply, nobody really knows what impact a voucher plan will have on beneficiaries and on the medicare program. As the medicare program is currently constituted, the health insurance trust funds do not pay out funds until an expense has been incurred. Under a voucher system, the program would pay a specific amount for each beneficiary who elects the voucher prior to expenses being incurred. This approach can result in substantial savings only if those who elect the voucher system turn out to be the medicare beneficiaries who use the greatest amount of services. If "regular" medicare keeps all of the "bad" risks and the private coverage attracts only "good" risks, the voucher system could end up costing the government more, since the voucher amount would be determined on a percentage of the high costs for medicare beneficiaries who remain in the regular program. Due to this problem, known as adverse selection, the voucher program could face many of the same problems that have recently plagued the Federal employees health benefit plan.

It is also unclear whether a private insurer could compete with medicare in light of medicare's underpayment of physician fees and hospital costs. Medicare is reported to be paying for hospital services at 20 percent less than costs, and physician reimbursement is fixed at arbitrarily low levels. Private insurers are also faced with costs that would not be reflected in the medicare 95 percent allocation.

While we do not support this provision as presented in the President's fiscal year 1984 budget, we continue to support demonstrations and experiments with the voucher approach.

Another proposal opposed by the Iowa Medical Society put forth by the Reagan administration proposes that eligibility for medicare be deferred to the first day of the month following one's 65th birthday. Under existing law, a person is ordinarily covered by medicare on the first day on the month in which he or she reaches the age of 65.

While we agree that it would not likely result in a gap of insurance coverage for most people, it would result in shifting costs to the private sector and the beneficiaries rather than reducing health care costs.

The Reagan administration also proposes to increase the premium for medicare part B to cover 35 percent of the costs of the program and to index the part B deductible. These actions would occur after a 6-month freeze of the part B premium.

The Iowa Medical Society supports this proposal. It is in keeping with the original intent of the medicare program in that originally the program was to be funded only one-half by general revenues. Medicare, like insurance programs, should have appropriate front-end copayments and deductibles. We would recommend, however, that rather than tying the index of the part B deductible to the overall consumer price index, the index should be tied to the medical care component of the CPI to reflect more accurately changes in the cost of medical services.

Finally, the Reagan administration proposes a new catastrophic hospital benefit with new copayment requirements for medicare beneficiaries. At present, medicare hospital coverage expires after 150 days of hospitalization during a "spell of illness," with escalating patient copayments at the 60th, 90th, and 120th days. All covered hospital costs would be paid by medicare after 60 days' hospitalization each year. The proposal, however, would also alter the current formula for beneficiary cost sharing by providing for new patient cost sharing from the second through the sixtieth day. The current first-day deductible would remain, but would be incurred no more than twice yearly.

The Iowa Medical Society supports catastrophic coverage for medicare beneficiaries, with appropriate copayment during early hospitalization. We are concerned, however, with the amounts of copayments proposed by the administration and the timing of their imposition. We believe that it would be more equitable for copayments to be imposed later than the second day of hospitalization. We also note that the administration's specific proposal requires copayments significantly higher than necessary to fund the costs of the additional catastrophic coverage. This would in fact transfer from medicare to the beneficiaries either directly or through increased premium costs for supplemental coverage. A coinsurance adjustment that is not substantially greater than the cost of the catastrophic benefit would be more equitable. We urge you to consider these concerns in reviewing proposed changes to the medicare program.

In conclusion, the Iowa Medical Society appreciates the opportunity to provide its views relative to the medicare program to the Senate Special Committee on Aging. As stated earlier, we are presently unable to comment on every possible reform proposal at this time. However, we look forward to working with the American Medical Association in its comprehensive review and study of the problems confronting the medicare program and possible solution to those problems. We hope to provide additional and ongoing comments as the deliberations of the committee continue.

ITEM 2. LETTER FROM JOHN M. RHODES, M.D., IOWA MEDICAL SOCIETY, TO SENATOR CHARLES E. GRASSLEY, DATED FEBRUARY 2, 1984

Dear Senator Grassley: Thank you for your letter of January 6, 1984. An attachment to the letter asks for questions in followup to my testimony submitted to you regarding medicare. I was unable to personally submit the testimony in Sioux City on December 13, 1983 due to the bad weather.

You ask alternatives which would affect "traditional" providers. I believe we are already to the point where there is no such thing as a "traditional" provider. Steady advances in technology, coupled with better training opportunities for allied health professionals have made it possible for nearly all physicians to be more reliant on technically skilled allied health personnel. As a result, more and better care is being provided. Allied health professionals supplement the practice of medicine; however, they cannot be substituted for physicians. So while they will play a valuable and expanded role in the delivery of care, there is also an expanded need for physician oversight. All of this is subject to the limitations each State places on the legally defined role of each allied health practitioner group. There is a future role for "alternative" providers of care, but there is a need to assure the quality of the overall delivery system through state laws and physician oversight.

You are correct that physicians are supportive of the status quo as reflected in a recent Harris poll. However, this satisfaction, which I believe is shared by Iowa physicians, is with the quality and amount of care available to any patients today. It is a satisfaction with our ability to provide care we were unable to provide just 5 years ago, not our satisfaction with current reimbursement systems.

It would be contrary to our training to support changes in the health care delivery system that would cause to move backward rather than forward in our ability to deliver quality care. We appreciate the need to experiment with new reimbursement policies which will allow us to continue to provide high quality care more cost effectively. This is why the American Medical Association and the Iowa Medical Society both support experimentation with new reimbursement systems on a limited basis. If cost savings can be accomplished without sacrificing quality, I believe physicians will support a departure from the status quo. However, untested changes introduced on a wholesale basis, such as the new DRG reimbursement system are opposed because of unknown factors which could negatively impact on quality.

You ask what sacrifices can be expected from physicians. First, we must move away from the premise that medicare is a welfare program; it is not. There are significant numbers of medicare beneficiaries who are of substantial means.

Second, since the inception of the medicare program, medicare "reasonable" charges have steadily fallen behind usual, customary and reasonable reimbursement levels for physician services. Despite this, physicians have not avoided their responsibility to threat medicare patients. National statistics indicate a very high rate of physician assignment.

I believe Iowa physicians, as is the case with many physicians nationwide, are willing to consider temporary freezes and possibly roll-backs in reimbursement to help deter costs to the medicare program. However, acceptance of assignment should not be mandated. As indicated early, many medicare beneficiares are in a financial position to pay for their care. And for those who are not able to pay, we pledge our cooperation in helping to assure assignment is accepted as payment in full.

You ask how quality care can be assured in an environment of cost consciousness. You will always be able to count on the physician as the chief advocate of quality care. I hasten to point out that cheap care is not necessarily the best care. We need to have continued incentives to provide not only cost effective, but quality care as well. Reimbursement systems, such as DRG's, may or may not save money, but the incentive is to save money, rather than provide quality care.

I believe physicians agree costs should be considered when evaluating the feasibility of new medical technologies, but it should not be a primary determinant.

You can be assured that physicians will continue to advocate that a patient, with the assistance of his or her family and physician, should determine how much care he or she receives. It is a physician's obligation to cure when possible. Decisions such as what medicare patients will not receive care and who will pay for the care that is provided are societal decisions, not ones to be made by physicians alone. If a physician believes a patient can be helped, the physician will provide the needed care.

Thank you for the opportunity to respond to your questions as well as the opportunity to provide initial testimony regarding the future of Medicare.

Sincerely,

JOHN M. RHODES, M.D.

ITEM 2. LETTER AND ENCLOSURE FROM PAUL E. BROWN, PRESIDENT, IOWA LIFE INSURANCE ASSOCIATION, DES MOINES, IOWA, TO SENATOR CHARLES GRASSLEY, DATED DECEMBER 23, 1983

DEAR SENATOR GRASSLEY: Thank you for the invitation to attend the hearing held in your capacity as a member of the Senate Special Committee on Aging to discuss problems of medicare. Your first notice arrived after the scheduled hearing date and the second notice arrived on the postponed date of the hearing.

However, I have been in touch with our trade association, the Health Insurance Association of America, to ask them to send me whatever would be appropriate. At the moment we are still concerned about the cost shift that takes place which may be enhanced by the new DRG system of payment. Besides that, it is my understanding that there is some staff work planned early next year and I will make certain that you get a copy as soon as it is available to me.

In the interim, if the hearing comments are available, we would appreciate a copy.

Thank you again for the invitation. We are looking forward to seeing you at the January fund raiser. Have a good holiday.

Sincerely yours,

PAUL E. BROWN, *President.*

Enclosure.

PROSPECTIVE PAYMENT

A Sound Approach to Containing Hospital Costs

Foreword

Prospective payment for hospitals, a new approach to moderating the persistently rising costs of health care, is fast gathering public support.

When prospective payment applies to *all* payers of health care services, as it now does in several states, a Fair Payment System is created.

The private health insurance business urges the adoption of Fair Payment systems in all states and for every hospital. Why all groups have a vital stake in this basic reform of the way hospitals are paid for services is the focus of this booklet.

On March 24, 1983, Congress enacted landmark legislation that significantly changes the way hospitals will be reimbursed for Medicare patients.

The Social Security Amendments of 1983 replace the cost-based system of reimbursement—paying most hospitals whatever they spend—with a new "prospective" system, which determines in advance the amount a hospital will be paid for a particular patient diagnosis.

The Health Insurance Association of America (HIAA) believes that such a prospective payment system is a major step toward moderating increases in hospital cost. However, any system that does not apply to all patients—whether covered by private or government plans—will not achieve the desired reform in hospital practices.

In testimony before Congress, the HIAA has pointed out that true cost containment cannot be achieved unless all patients pay on the same basis for the same services.

The HIAA, therefore, has called for *fair payment* through an all-payer prospective pricing system.

How the Problem Evolved

The cost of medical care continues to increase at a rapid pace. In fact, health care is the fastest growing component of the Consumer Price Index. While the general rate of inflation was 3.9 percent in 1982, hospital daily service charges rose 13 percent.

The average cost of a day in a hospital semi-private room has risen dramatically, from $91 in January 1977 to $184 in January 1983. As a result of these increases, annual health insurance premiums have been rising to keep pace with prices and use of services.

Under current federal and state regulations, the government pays less than its fair share of expenses incurred by hospitals and physicians treating Medicare and Medicaid patients. To compensate for these government reductions in reimbursement, health providers shift costs to private-paying patients, resulting in higher charges.

The HIAA has estimated that Medicare/Medicaid payment practices resulted in a "cost shift" to the private sector of $5.8 billion in 1982. Current estimates put the cost shift for 1983 at $7.9 billion.

What Causes the Problem

Medicare and Medicaid payments for hospital services fail to recognize certain necessary costs. Medicare pays hospitals retrospectively, reimbursing for costs after they are incurred. Hospitals assume no financial risk under this system and have no incentive to be cost-effective.

Since 1965, government health care expenditures have been rising dramatically. During this period, the government's reimbursement rules have been continuously changed in order to reduce government payments. These reductions have not reduced overall spending, they have simply shifted more and more hospital costs to private patients.

The following are a few examples of steps the government has taken to reduce its program liabilities:

■ The Secretary of Health and Human Services (formerly HEW) has almost unlimited authority to determine the level at which hospital costs will be recognized for reimbursement purposes.

■ Certain legitimate hospital expenses such as the costs associated with bad debts, charity care, education and research are excluded from the government reimbursement formula.

■ Federal law requires hospitals to supply medical data to Peer Review Organizations (PROs) which contract with the federal government to review the utilization patterns of Medicare and Medicaid patients. Hospitals which refuse to provide PROs with similar data on private patients cannot be forced to do so. Therefore, different patterns of utilization for government and private patients may result, which only compounds the cost-shifting problem.

These and other measures redefine Medicare/Medicaid "reasonable cost" in such a way as to permit government payments to fall further and further below an adequate rate. Hospitals have thus been forced to raise charges to private patients disproportionately in order to meet their expenses. Furthermore, there is every indication that Medicare and Medicaid reimbursement rules are likely to tighten even more in the future.

How The Shortfall Has Grown

As the chart below shows, the shortfall in government payments continues to rise.

Faced with this shortfall in revenue, hospitals have two choices: they can draw upon available hospital reserves, if any, to make up the deficit, or they must overcharge patients who are not under government programs.

Most hospitals adopt the second option to preserve their fiscal integrity. Thus, government payment practices lead directly to differentials in payment between government and private patients. The end result of lower Medicare/Medicaid payments is cost-shifting to private patients, *not* cost containment.

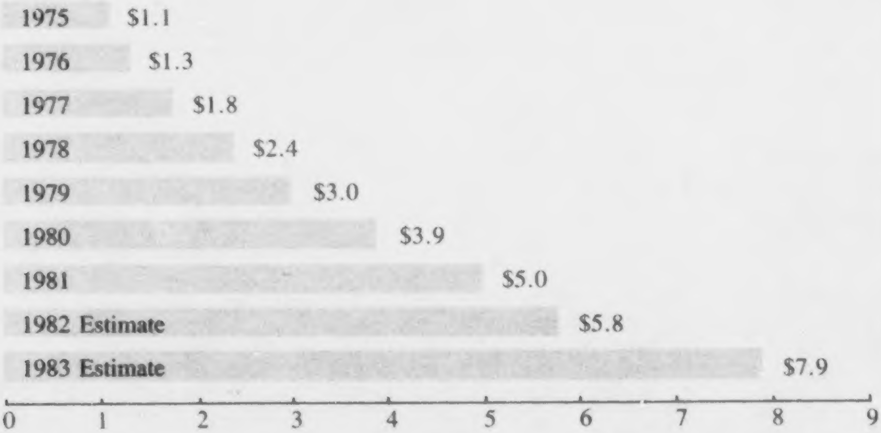
Employers and private sector patients are feeling this cost squeeze and are becoming increasingly frustrated that a large portion of their hospital bills is not for their own care—over which they may have some control—but for care given to other patients. In fact, a typical private sector hospital bill would be nearly 13 percent lower in the absence of the government cost shift.

Efforts to contain health care costs for all patients are undermined when:

- All costs of providing hospital services, including bad debts and charity care, are picked up by only some patients; and
- cost containment efforts by one payer can be offset by increasing charges to other payers.

In addition, the financial stability of many hospitals is threatened, particularly teaching and inner-city community hospitals with high numbers of Medicare/Medicaid and uninsured patients, and few private paying patients to whom costs can be shifted.

1975-1983 U.S. Short Term Hospital Total Government Payment Shortfall (In Billions of $)



The current system simply encourages hospitals to spend money in order to obtain more. If a system reimburses hospitals for daily charges, a hospital administrator may cover fixed costs by encouraging weekend admissions for Monday surgeries. If every laboratory test generates a separate reimbursement, a hospital administrator can encourage use of ancillary services by bringing in new and more costly equipment.

The participants in the health care marketplace agree that incentives in the hospital industry are misplaced. In recognition of this, the major hospital trade associations are on record in support of system reform based on prospectively-determined prices.

The New Medicare Prospective Pricing System

Medicare's new prospective payment system will pay hospitals on the basis of "diagnosis-related groups" (DRGs). Under this approach, hospital rates—not physician fees, however—are pre-determined for each specific diagnostic category, regardless of length of stay or extent of services provided.

In this way, hospitals know, in advance, how much they will be paid for treating a Medicare patient. Hospitals which operate below the pre-set DRG level will profit, thus providing them with a strong financial incentive to reduce costs and a reward for efficient delivery of health care.

By keeping costs below the approved DRG limit, a hospital can produce an operating surplus which can be applied to new programs and services, or simply contributed to its reserves to help assure the institution's financial stability.

The new Medicare payment program, in place on October 1, 1983, will be phased in over three years. During this transition, each hospital's Medicare payments will be based on a combination of its actual costs and the Medicare DRG rate.

Why Won't The New Medicare System Solve The Cost Shifting Problem?

While the new Medicare prospective payment system marks a dramatic change in the way hospitals are paid, such a plan will not produce the desired effect on hospital behavior. Theoretically, hospitals with cost overruns will have to absorb the losses. However, in reality, hospitals will continue to shift their losses onto non-Medicare patients.

The State Solutions

Notably, the Social Security Amendments of 1983 authorize states to adopt hospital cost containment programs that would allow Medicare to pay fair charges and eliminate cost shifting.

In order for states to implement their own fair payment systems, however, the federal government must "waive" its usual reimbursement regulations, allowing Medicare and Medicaid to pay on the same basis as all other payers. The government has participated in such state systems, and now is authorized to continue its participation, because of the positive incentives for cost containment.

Maryland and New Jersey have had state prospective payment programs in place for several years, and have exhibited a rate of increase in hospital expenses below the nationwide rate.

Since the federal waiver went into effect in Maryland in 1977, hospital charges for private patients have risen at a rate well below the national average. In 1982, hospital net patient costs per patient day rose 14.2 percent, compared with a national figure of nearly 17 percent.

The Maryland Health Services Cost Review Commission reports that from 1978-1981, approximately $124 million was saved in Medicare and Medicaid payments to hospitals.

In addition, such a state review system protects inner-city hospitals from losses resulting from charity cases and bad debts, which were not covered by Medicare before the waiver. All of the hospitals in the state are reported to be financially sound.

In Maryland, as elsewhere, the Medicare program is guaranteed against program cost increases. Congress has written such a provision into the Social Security Amendments. Under the law, if the federal government finds that, over any three-year period, Medicare has paid more under the state system than it would have paid otherwise, it may reduce subsequent Medicare payments to hospitals under the system by that amount.

In New Jersey, where a DRG system was implemented, participating hospitals have reported cost increases almost five percent lower than the national average. While eight of the hospitals were suffering from deficits before the program was implemented, six are now financially solvent.

Though both states have slowed the rate of hospital cost escalation, there is no indication that either quality of care or patients' access to appropriate services has declined as a result of these cost control systems.

In summary, the all-payer systems in Maryland and New Jersey are:

- Slowing down the rate of increase in hospital costs for all patients;
- Authorizing fair payment for all payers; and
- Providing incentives for hospitals to reduce utilization.

Massachusetts and New York are the latest states to establish cost containment programs. Maine and West Virginia recently passed legislation and will soon implement an all-payer system suitable to their own needs. Prospective payment proposals currently are being developed in a number of other states.

The HIAA Position

The HIAA supports the adoption by each state of a prospective payment system, tailored to its own requirements. The Association does not believe that a single, federally controlled all-payer program would be in the best interests of the health care system and its patients. No single model can suit every community's needs.

While DRG-based plans may be suitable for some states, different systems may work better for others. To this end, the HIAA has undertaken efforts in several states to promote legislation that creates appropriate ways to establish payments to hospitals prospectively and fairly.

In addition, the HIAA would support federal legislation that encourages the development of state prospective payment systems, but also provides a residual federal system of prospective pricing for all payers in states that have not adopted their own systems within four years of the effective date of the measure.

Such a measure would give every state time to enact legislation tailored to its own particular requirements and yet guarantee that all citizens obtain the protection they need.

While states have the flexibility to design their own systems, the HIAA believes they should share these characteristics:

1. Rules set in advance for all hospitals in the state;
2. Incentives and penalties for hospitals designed to encourage cost-effective management;
3. Fair payment for *all* patients regardless of the third party payer (private or government) involved;

4. Payer discounts based upon objective factors that result in demonstrable cost savings to the hospital;
5. Monitoring use of certain hospital services; and
6. Uniform cost and utilization reporting requirements for all hospitals.

The HIAA has termed this broad approach involving equitable and prospective determination of rates a "Fair Payment System." Significantly, the new Medicare prospective payment legislation requires:

- An annual report to Congress on the impact of the Medicare-only prospective pricing system; and
- A report by January 1985 describing the full extent of cost shifting and the feasibility of implementing an all-payer prospective payment system.

Other Initiatives

Toward effecting long-term change in hospital payment incentives, the HIAA has called for appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations to Congress. Such a body should be composed of representatives from the business community, labor, health care providers, private health insurers and federal and state governments.

In addition, the HIAA and its member companies support legislation which would permit insurance companies to join together in the effort to bring health care costs under control.

Hospitals have had few incentives to economize, and insurance companies have been unable to negotiate jointly for better prices and services. Appropriate legislation would permit companies to do so.

Such a measure would also allow companies to cooperate in collecting, sharing and using health care data to analyze costs and quality of care.

Summing it up

Enactment of the Medicare prospective payment legislation has paved the way for all-payer "Fair Payment" systems at the state level. Clearly, existing state programs demonstrate that such a system, with a Medicare waiver, can dramatically reduce the rate of increase in hospital costs paid by private sector patients.

The savings incentives created by the Medicare proposal are effective only if applied to all patients. Such a system should encourage hospitals to operate more efficiently within the particular state system adopted.

The foundation for all-payer systems is now in place. States must follow the lead of the Medicare system and develop their own Fair Payment programs, designed to meet local health care and economic needs.

The HIAA currently is working on model legislation to assist states that wish to consider this sound approach, and its staff is available for technical assistance to interested state constituencies.

Together, hospitals, government, industry, health insurers and consumers can, through a Fair Payment System with rates established prospectively, solve the cost shifting problem and contain spiraling costs of health care.